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WORK-LIFE EXPERIENCES OF EMPLOYEES WITH BIPOLAR DISORDER

BİPOLAR BOZUKLUK TANISI ALMIŞ ÇALIŞANLARIN İŞ YAŞAMI DENEYİMLERİ

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to all stigmatized identities

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ABSTRACT

The present study aims to investigate the work and workplace experiences of employees with bipolar disorder. In the modern world, people diagnosed with psychological disorders may hide their psychological disorders from third people, groups, or institutions because of the potential for exclusion from various social settings; and, the work settings would take the first place in the list. Therefore, one of the significant social issues of today is to fight against the stigma attached to psychological disorders. Even if these people might be functional following the episodes, most of the time, the work settings are reluctant to let them work. Therefore, the main research question of the study is related to professional life of employees with bipolar disorder. How working conditions, work settings, and professional interrelationships affect them is the main focus of the current study which is the first research in Turkey on this target group. The aim is not just to reveal their individual experiences but also study cultural perspectives over bipolar disorder in working environment. Semi-structured in-depth interviews were conducted with ten interviewees who are diagnosed with bipolar disorder. After the ethics approval of İstanbul Bilgi University, Çapa Medical School in Istanbul (Psychiatry Department) and Bipolar Life Association in Istanbul are reached out for the volunteers to participate in the research. Inclusion criteria were being a white-collar employee (currently working and non-working) and being diagnosed with bipolar 1 or 2 disorders. MAXQDA qualitative data analysis program was used with the analytic principles of Interpretative Phenomenological Analysis (IPA) to analyze data. The master themes emerged as follows: “the reflections of symptoms of mania in the workplace”, “the reflections of symptoms of depression in the workplace”, “disclosing the diagnosis”, “difficulties in work-life”, “working and meaning” and “society, family and human resources management professionals’ perspectives on bipolar disorder”.

ÖZET

Bu çalışmanın amacı bipolar bozukluk tanısı almış çalışanların iş ve işyeri deneyimlerini incelemektir. Modern dünyada, psikolojik bozukluk tanısı almış olan insanlar aldıkları tanılarını, dışlanma potansiyeli sebebiyle çeşitli sosyal ortamlardan üçüncü kişilerden, gruplardan veya kurumlardan gizleyebilir; ve iş ortamı listede ilk sırada yer almaktadır. Bu nedenle, günümüzün en önemli sosyal sorunlarından biri, psikolojik bozukluklara yönelik damgalanmaya karşı mücadele etmektir. "Bipolar bozukluk aynı zamanda semptomatik belirtileri ile az miktarda ilişkili görünen bir dizi sosyal ve mesleki komplikasyona sahiptir" (Goldberg & Harrow, 1999, s. 59). Açıkça, bu insanlar atakların ardından işlevsel olsalar bile, çoğu zaman iş ortamı onların çalışmasına izin vermekte isteksizdir. Çalışmanın temel araştırma soruları: Çalışma yaşamının hangi bileşenleri bipolar bozukluğu olan bir çalışanla ilişkilidir? Çalışma koşulları, çalışma ortamı ve profesyonel ilişkiler bipolar bozukluk tanısına sahip insanları nasıl etkiler? Bu çalışma, Türkiye'de bipolar bozukluğu olan çalışanların deneyimlerini içerecek ilk çalışma olacaktır. Amaç, sadece katılımcıların bireysel deneyimlerini ortaya koymak değil, aynı zamanda çalışma ortamında bipolar bozukluk üzerine yapılan kültürel bakış açısını da incelemektir. Yarı yapılandırılmış derinlemesine görüşmeler bipolar bozukluk tanısı almış ve iş tecrübesi olan on görüşmeci ile yapılmıştır. İstanbul Bilgi Üniversitesi'nin etik onayının ardından, İstanbul'daki ÇAPA Tıp Fakültesi (Psikiyatri Anabilim Dalı) ve Bipolar Yaşam Derneği aracılığıyla gönüllü katılımcılarla temasa geçildi. Örnekleme grubu beyaz yakalıdır ve bipolar 1 veya 2 tanısı almış olan kişilerden oluşmaktadır. Veriler, Yorumlayıcı Fenomenolojik Analiz'in analitik prensipleriyle MAXQDA nitel veri analiz programı ile analiz edilmiştir. Çalışmada, temel bulgular ana temaların "mani döneminin iş yaşamına yansımaları", "depresif dönemin iş yaşamına yansımaları", "tanının paylaşılması", "iş yaşamında yaşanılan zorluklar", "çalışmak ve anlam" ve "toplum, insan kaynakları profesyonelleri ve ailenin tanıya bakış açısı" olduğunu göstermiştir.

CHAPTER 1

INTRODUCTION

The present study aims to investigate the work and workplace experiences of employees specifically with bipolar disorder. In the today's modern world, people with the diagnosis of psychological problems seem still hiding their psychological disorders from third people, groups, or institutions because of the potential for exclusion from various social settings; and, the work settings would take the first place in the list (Layard, 2005, p.2). Since many people have a bias for people with bipolar, schizophrenic, obsessive-compulsive disorders, and other psychological problems, people with these diagnoses frequently hide it from surrounding friends or environment since they can be perceived as "suicidal", "prone to violence and homicide" or emotionally imbalanced person who may cause uncertainty in the dynamics of interrelationships, and their functionality is usually questioned.

This stereotypic social perception is also nurtured by sources like media, news from television channels or newspapers and stereotypic film figures. These misrepresentations shape people's perception who have not sufficient information about psychological disorders that are indeed very natural and humane issues. Therefore, fighting against the stigma attached to psychological disorders is one of the significant social issues of today, which are made more visible with the help of non-governmental organizations aiming for human rights protection. Moreover, many famous artists disclose themselves in public settings. For example, Nurseli İdiz in Turkey and Britney Spears, Kurt Cobain around the world disclosed themselves as being bipolar. These figures can help to reduce biases towards people who experience disadvantages due to their psychological disorders and empower people to keep their psychological functioning.

Goldberg and Harrow (1999) define psychosocial functioning as a measure that "takes into account multiple areas of adjustment, including work and social adaptation, life disruptions, self-support, symptoms, relapse, and rehospitalization" (p. 6). Capacity to work is one determinant of psychosocial functioning. The work-

life is part of the treatment for psychological problems in general and bipolar disorder in specific. According to Goldberg and Harrow (1999), social service agencies and job retraining services encourage patients to look for work and help in preventing relapse and improving long-term recovery of manic and depressive episodes. However, they point out that *"*For the six months after an acute manic or depressive episode, 57% of patients cannot maintain employment, and only 21% work at their expected level of employment, even when they are relatively symptom-free and maintained on standard drug regimens. The likelihood of maintaining employment decreases as the patient's disorder becomes more chronic*"* (Goldberg & Harrow, 1999, p. 59). Even if these people might be functional following the attacks, most of the time, the work settings are reluctant to let them work.

Mental health problems are considered as social and global issues that need to be solved. It is examined that at least 10 percent of the world's population is influenced. Countries ignore this "invisible" problem and do not make policies or intervention methods to solve it so that in terms of stigma and related matters it is a burden ("Mental Health" Report, 2019). Societies allocate budgets for somatic diseases such as cancer, diabetes or/and rheumatism (Trautmann, Rehm, & Wittchen, 2016,. On the other hand, a budget is not given for mental disorders as much as the budget for somatic diseases.

We may talk about the direct and indirect costs of mental disorders from the perspective of human capital. Hospitalization and other healthcare costs are examples of direct costs, as productivity and income losses are indirect costs. Work and work-related issues (absenteeism or early retirement) refer to indirect costs too (Trautmann, Rehm & Wittchen, 2016,).

Similarly, the World Health Organization (WHO) research predicts that *"*... depression and anxiety disorders cost the global economy US$ 1 trillion each year in lost productivity" ("Mental Health in the Workplace" Report, 2019). The report also emphasizes unemployment as a well-known risk factor for psychological health problems, and having a job or returning to a job after the treatment protects from recurring mental health problems and relapses. Another

WHO-led study (2019) shows that devoting effort to address this issue brings net benefits. For instance, for every US$1 spent for treatment of psychological disorders, US$ 4 returns as better health and productivity.

Even if this is a critical social problem, a literature review is not still providing comprehensive academic resources on experiences of employees with bipolar disorder. Current literature is limited related to the following questions on behalf of current employees or for those who are at the stage of job search: What ways does the professional life relate to being an employee with bipolar disorder? How working conditions, work settings, and professional interrelationships affect people with bipolar disorder?

Moreover, especially for Turkey, we do not have sufficient knowledge about the employees' work-life experiences with psychological problems in general or specific to bipolar disorder. The few studies that investigate the stigma in the general population toward bipolar people (e.g. Kök & Demir, 2018) do not provide information about specific workplace experiences. The current thesis mainly focuses on these questions.

1.1.Bipolar Disorder

The psychological disorder or abnormal behaviors have been discussed for years, whether a situation is a disorder. Even if this philosophical discussion is not the main subject of the current thesis, it would be useful to give a criterion of whether something is a disorder or not. According to Diagnostic and Statistical Manual of Mental Disorder 5 (DSM-5), it is more appropriate to define some behaviors as "abnormal behavior" in case of disruption or disturbance of functions in some areas, which are occupational, social, or other vital areas (DSM-5, 2013, p.21). Clinicians consider biological, psychological and social factors in order to make comprehensive and reliable diagnoses (DSM-5, 2013).

According to "The Nice Guideline on the Assessment and Management of Bipolar Disorder" (National Collaborating Centre for Mental Health-UK, 2017), bipolar disorder, also formerly known as "manic-depressive illness," is a psychological disorder under the umbrella of mood disorders Nowadays, bipolar

disorder is periodic/seasonal mood disorder involving mania or hypomania which are defined as higher mood, and depression as the opposite emotional state of mania. These periodic episodes disrupt a person's daily life activities being occupational, family, social, or/and romantic relationships. Mania is depicted with inflated self-esteem (grandiosity), decreased sleep, irritable affect, while depression is defined as feeling sad, empty or hopeless, disruption of sleep patterns (insomnia or sleeping excessively), and fatigue (DSM-5, 2013).

Furthermore, there are no psychological tests to detect the bipolar disorder. Considering the history of the client and making careful observations and interviews by clinicians guide the accurate diagnosis (Bauer, Ludman, Greenwald, & Kilbourne, 2009) with the symptoms listed in Table 1.1. according to DSM-5 (2013):

Table 1. 1. Symptoms of Manic and Depressive Episodes

Manic Episode	**Depressive Episode**
Exaggerated grandiosity or self-esteem	Feeling grievous, hopeless, and empty
Reduced sleep need	The diminished motivation for all activities
Excessively communicative and talkative	Weight and appetite changes
Having racing thoughts	Sleep issues (insomnia or hypersomnia)
Having more destructions than usual	Agitation or retardation
A rise in goal-oriented activities	Feeling fatigued or loss of energy
Taking more risks than usual	Feeling excessive guilt and uselessness
	Concentration problems
	Repeated suicidal thoughts

Table 1.1. helps to understand the differences and similarities between these two mood changes. Hypomanic episode's symptoms are the same as the symptoms of manic episodes. However, hypomanic episodes last at least four days, but manic episode finishes as long as a week. The duration of depressive episodes is a minimum of two weeks (DSM-5, 2013, p. 124-125).

1.2. Treatment of Bipolar Disorder

Firstly, it is essential to emphasize that the treatment of each person may require a unique procedure shaped by the nature of potential co-occurring problems like alcoholism, substance abuse, comorbidity with personality disorders or/and other severe psychosocial problems (Goldberg & Harrow, 1999).

Mainly, there are two intervention approaches to treat the disorder: pharmacological and psychosocial. During manic episodes, antipsychotic drugs are used to minimize the symptoms. The pharmacological treatment of bipolar depression is a complicated process; because, the use of antidepressant medications requires caution since some of them can trigger mania/hypomania so that usually low-dose serotonin-containing antidepressants are given. Moreover, lithium or other drugs with regulative mood effects are used for preventing the acute episode and the relapse (National Collaborating Centre for Mental Health-UK, 2017).

Individual and group psychoeducation, cognitive-behavioral therapy, interpersonal and social rhythm therapy, and family-focused therapy are among the psychosocial interventions. If we give brief information about these techniques, individual and group Psychoeducation aims at managing the disorder and recognizing possible episodes signals early relapse (National Collaborating Centre for Mental Health-UK, 2017). Cognitive-behavioral therapy highlights individual skill developments and decreases of recurrent negative emotions, which are mainly occurring during the depressive episode (Lauder, Berk, Castle, Dode, & Berk, 2010). Interpersonal and social rhythm therapy is interested in social and personal relationship problems and organizing daily routine activities such as; work-life balance, sleep-wake cycle, or/and other daily activities (National Collaborating Centre for Mental Health-UK, 2017). Family-focused therapy includes informing family members about bipolar disorder and establishing healthy relationships in the family in order to prevent family conflicts that may trigger relapses (Goldberg & Harrow, 1999).

1.3. The Function of Work for People with Bipolar Disorder

Work is an essential component of our daily and social lives since it shapes people's identities. For example, in the settings of socializing or meeting new friends, the mention for occupations and jobs is the usual pattern (Judge & Klinger, 2008). According to Freud, besides love, work is one of two sources of well-being (Bauer, Ludman, Greenwald, & Kilbourne, 2009).

Moreover, the salary, promotions, coworkers, supervision, work content, recognition, working conditions, company culture, and management determine how satisfied people will feel at work. Following the strong relationship between job satisfaction and life satisfaction, as highlighted in many studies (Judge & Klinger, 2008), the responsibility of organizational psychology is to let people get satisfied in their work settings that will support psychological well-being and health.

Marie Jahoda (1981), who was interested in the latent needs of work, claimed that paid work/employment fulfills particular psychological needs like social interaction and a sense of purpose which in turn influences psychological health (Sage, 2017):

(a) Work organizes the day and creates a routine (Furnham, 1992). Here, it is worth mentioning the emphasis on creating a regular life that is always emphasized as a critical requirement in the treatment of bipolar disorder (National Collaborating Centre for Mental Health-UK, 2017).

(b) It brings every day a chance for social interaction. Professional life providing regular social relationships and socializing with co-workers (Furnham, 1992) supports psychological health. As Maslow (1943) highlights socializing as a crucial need (Furnham, 1992, p. 129), research on the relationship between social isolation and psychological illnesses brings support for this idea (Furnham, 1992).

(c) People sense the feelings of mastery, purpose, meaning, and creativity through working, which causes job satisfaction, on the one hand, to prevent the sense of meaninglessness and uselessness on the other (Furnham, 1992).

(d) Many activities of the work requiring physical and mental effort energize people. Undoubtedly, these activities should be in balance because being overloaded can cause fatigue, anxiety, and stress, while fewer activities lead to boredom and discontent/restlessness (Furnham, 1992).

As working is an essential dimension of psychosocial support to prevent relapses and to organize daily activities (Goldberg & Harrow, 1999), losing a job can have a damaging effect on the individuals (Lauder, Berk, Castle, Dode, & Berk, 2010). For example, Goldberg and Harrow (1999) mentioned Mr. B's case in order to express the function of work. Mr. B (as mentioned from the original book) who was experiencing recurrent episodes began to undergo fewer episodes after starting to work (p. 49-50).

1.4. Stigma toward People with Bipolar Disorder

Erving Goffman (1963) defined "stigma" as a devalued feature of an individual that damages character, honor, or position through its connection with negative patterns. Structural stigma, public stigma and self-stigma are the three forms of stigma researchers study (Cassidy & Erdal, 2019; Corrigan, Markowitz, & Watson, 2004). Structural stigma refers to "societal-level conditions, cultural norms and institutional practices" that limit the favorable circumstances, resources, and well-being of stigmatized identities (Hatzenbuehler & Link, 2014). It occurs at state-level policies that cause social exclusion. Employment and housing discrimination could give an example of structural stigma (Pugh, Hatzenbuehler, & Link, 2015). Public stigma includes the society's negative beliefs, attitudes, and biases toward stigmatized identities -especially mentally ill people for this study- (Corrigan, 2004). Public stigma has destructive and damaging effects on people with psychological disorders, and it is related to self-stigma because self-stigma begins by internalizing the public stigma (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012). Self-stigma leads to adverse affective states, such as lowered self-esteem and self-efficacy which leads people to isolate themselves from society and the institutions (Corrigan & Rao, 2012).

1.5. Aim of the Study and the Research Question

As it is known, there are various ways to approach to qualitative data, but each of them aims to reveal people's understanding and knowledge of their world (Ashworth, 2015). If well-being researches are considered in particular, it is crucial that they should be qualitative since most of the views expressed in the face of well-being are subjective. For example, someone can describe "good emotional quality" as excitement, others may explain as calm (Thin, 2018).

Furthermore, individuals with bipolar disorder undergo subjective and unique experiences. To give an example, some of them can experience psychotic symptoms in mania, but some do not (Joe, Joo, & Kim, 2008). One of the principles of qualitative research is putting each participant's experience at the core (Smith, Flowers & Larkin, 2009; Williams, McManus, Muse & Williams, 2011). Moreover, Interpretative Phenomenological Analysis (IPA) which is one of the qualitative methods, aims to understand in detail the participant's perspective (Smith, Jarman & Osborne, 1999). Therefore, the interpretative phenomenological analysis method of the qualitative research will be preferred because of the concerns which are emphasizing subjective experiences, non-reductionism and more comprehensive study.

Jonathan Smith who has developed IPA, expresses that lived and subjective experiences are an essential locus of the method (Biggerstaff, 2012). This method is also trying to understand what surrounds us (Cohen & Omery, 1994). IPA intends to study how people establish the relationship between their experiences and their environment (Biggerstaff, 2012; Smith, 1999).

The current thesis focuses on demonstrating the unique experiences of employees with the bipolar disorder via qualitative research methodology, specifically, Interpretative Phenomenology. The main research question is related to how individuals with bipolar disorder experience and make sense of the work-life. In light of this primary research question, the following questions will elaborate and provide a framework:

a. How do individuals with bipolar disorder experience manic, depressive and stable/remission periods in work-life?

b. What are the difficulties they face in professional life and how do they cope with them?

c. What do they think about disclosing their disorder in work settings?

d. What is the meaning of working/being employed?

e. What do they think about the attitude of human resources professionals towards bipolar disorder?

CHAPTER 2

METHODS

2.1. Sampling

This study holds one sample group in İstanbul: individuals with bipolar disorder. The inclusion criteria for selecting the sample group are as follow:

- Being white-collar employees with bipolar disorder who are actively working.

- Being white-collar employees with bipolar disorder who are currently unemployed, but they should either have work experience, or had been in the process of employment interviews, and currently searching for a new job.

- Both of these interviewees must have been diagnosed with bipolar 1 or 2 disorders. The cyclothymic disorder is not included since its prevalence is lower than the other two groups (according to the recommendations of our collaborator in this thesis, Prof. Dr. Sibel Çakır from Bipolar Yaşam Derneği and Çapa Medical School, Psychiatry Clinics).

- The age range is between 26 and 49.

- Being diagnosed as bipolar disorder minimum in the past one year.

- Minimum university/undergraduate graduation because it is one of the essential conditions for being a white-collar worker.

Exclusion criteria are listed below;

- Having a different psychiatric diagnosis other than bipolar disorder.

- Hospitalization within the last three months.

- Being appointed as an “employee with a disability” by Turkish job placement agency (ISKUR) to the current organization. This is because of several reasons. Firstly, this state policy creates potential for smooth job placement for people with disabilities. Therefore those who search with their efforts or those who

apply to open positions announced by ISKUR may have diverse experiences. Secondly, this channel is not widespread among people with psychological disorders, most frequently people with physical disorders are using this opportunity, and for the current research, any participant with these characteristics may create an outlier effect.

Therefore, the distribution of the sample according to the parameters is provided in Table 2.1.

Table 2. 1. Sampling Structure

	Women	**Men**
Currently employed	2	2
Currently searching job	2	4

We do not expect the effect of gender on the constructs of current research; sex is a control variable in terms of demographic distribution. Moreover, occupation is not among sampling specifications.

Participants with bipolar disorder were accessed via Bipolar Yaşam Derneği. In this thesis, Prof. Dr. Sibel Çakır was acting as co-advisor who was Çapa Medical School Psychiatry department faculty member and one of the founders of Bipolar Yaşam Derneği. Prof.Çakır was the contact person to access to a bipolar sample of this research. Participants were either those who were among active members of the association or in regular contact with the network of association. In case that the association could not have brought the expected sample size, Prof. Çakır disseminated information about the research in Çapa Psychiatry department and her private office to her patients who are not currently active in the treatment process, i.e., former patients who completed/withdrew from the treatment were targeted. In order to prevent them from feeling obliged to participate, she contacted the patients informing them that İstanbul Bilgi University is organizing research on bipolar disorder, and ask if they are interested in hearing more about it. Therefore, she introduced the project briefly and asked if they were interested, Faruk Ceylan contacted those who agreed to get detailed information.

Before this thesis proposal, Faruk Ceylan and İdil Işık from İstanbul Bilgi University, Sibel Çakır from Çapa Medical School, Zeynep Maçkalı from İstanbul Arel University conducted one and half hour meeting about work-life and bipolar disorder at Çapa Medical Faculty on December 18, 2017. About 50 individuals who are a member of the association or those who want to hear more about the association or clients of Çapa Psychiatry Clinic attended the meeting. Some of the participants' parents have joined to the session as well. Indeed this meeting's participants represented our sampling so that the same announcement process as this meeting was utilized fo the current research too. Mainly, the association's website and Facebook page were the channels for the announcement.

As a result, 10 participants are sufficient as a sample size for IPA method. A unanimous answer about sample size for IPA is hard to find because articulation of individual experiences varies in terms of the depth. In some cases, one could be enough. However, if an answer is required, Smith, Flowers, and Larkin (2009) mention three participants as sufficient for master studies. We have decided to make more than three participants since a study of bipolar disorder and work-life is atypical for Turkey, and a more substantial perspective can be brought via larger sample size. However, the principle of theoretical sampling and saturation was also used as the primary guide to decide if more participants are needed.

2.2. Participants

As the outcome of the sampling process, we interviewed 10 people. Table 2.2. gives detailed information about participants' demographic characteristics.

Table 2. 2. Participants' Demographic Characteristics

	Year of Birth	**Place of Birth**	**Most Recently Graduated School**	**Gender**	**Marital Status**	**Working Status During the Interview**
Participant 1	1984	İstanbul	Bachelor's Degree	Male	Single	Unemployed
Participant 2	1993	İstanbul	Graduate Student	Male	Single	Actively Working
Participant 3	1970	Manisa	Bachelor's Degree	Male	Married	Actively Working
Participant 4	1987	Gaziantep	Bachelor's Degree	Male	Single	Unemployed
Participant 5	1976	İstanbul	Associate Degree	Male	Married	Unemployed
Participant 6	1990	Ağrı	Master's Degree	Female	Single	Actively Working
Participant 7	1977	İstanbul	High School	Female	Married	Actively Working
Participant 8	1984	İstanbul	Graduate Student	Male	Single	Actively Working
Participant 9	1976	Burdur	Associate Degree	Female	Divorced	Unemployed
Participant 10	1988	İstanbul	High School	Female	Divorced	Unemployed

2.3. Materials

Eight open-ended questions were used in the semi-structured interviews. Interview questions mainly focused on understanding the relationship between bipolar disorder's episodes and their impact on work-life; opinions about disclosing the diagnosis at work settings at the job placement phase or during the employment process; the meaning of work for people with bipolar disorder; and the perception of diagnosis in the society in general and among human resources management professionals in particular.

Interviews were started by asking them to introduce themselves and their job status, continued with "bipolarity and work-life relations" questions and lasted with asking about working and meaning. As the nature of the semi-structured interview protocol allows, the flow of the interview emerged other relevant questions to further elaborate participants' experiences.

2.4. Procedure

After the ethics form was approved by Istanbul Bilgi University Ethics Committee (Appendix 5), the interviews were conducted. Before the interview, the researcher explained the aim of the study and gave the consent form. In order to provide confidentiality and trustworthiness, the participants were informed that the identities of the participants would not be uncovered in any way and that the participants could withdraw the interview at any time. Furthermore, the information provided procedural details like protecting audio-recordings by password and accessing them anonymously only by the researcher and supervisor. Although the researcher provided this information, one participant (P8) said that he had a trust problem and would not mention his name in the voice recording and he wrote a nickname on the consent form.

Semi-structured in-depth interviews were conducted with the participants. Voice recording was done after receiving the approval of each participant. Depending on the participant's characteristics, responses, and other parameters, duration of the interview varied, but the interviews took 55 minutes on average.

Eight of the participants were interviewed one to one, while two participants (P4 and P10) accompanied one other person. When they requested to come to the interview with another person, we asked whether they could freely answer or not. They said that being accompanied by a person that they prefer could ease the process. Their companies did not intervene unless the question was explicitly asked for them and were not allowed to manipulate the participants.

Transcription of recordings to word processor was realized following the interviews, and data were systematically analyzed by the use of the MAXQDA qualitative data analysis program with the analytic principles of Interpretative Phenomenological Analysis. Faruk Ceylan as the primary researcher coded the data, the thesis advisor Dr. İdil Işık acted as the second coder.

In a couple of interviews, participants got emotional and cried. In order to prevent them from the potential of re-traumatization, the interviewer recommended stopping the interview; however participants preferred to continue. The researcher pursued the interviews with their consent and request; but, they were ensured that they could get support from the psychological counseling unit of Istanbul Bilgi University at any time. At the end of the interviews, a debrief was realized to check this need once again. However, after the interview sessions, no request to consult the psychological counseling unit emerged.

2.5. Data Analysis

In order to understand unique experiences (work-life and partly private life) of employees with bipolar disorder, the qualitative research method was chosen for this research. Experiences and reactions of people to specific situations are essential elements of qualitative studies (Elliott, Fischer, & Rennie, 1999). People in society tend to generalize individuals with bipolar disorder in the light of information about bipolar disorder which has been accessed from some links or websites by the internet. They can perceive the symptoms of bipolar disorder as individuals' personalities. In order to prevent these stigmatized attitudes, subjectivity and uniqueness of experience are emphasized in the qualitative studies.

Therefore, qualitative method consisting of semi-structured questions was chosen for revealing the individuals' experiences on a broad spectrum.

In order to reveal personal experiences, the IPA technique will be used to analyze data obtained from bipolar participants. Firstly, it is essential to emphasize that qualitative research is rooted in the philosophy of constructivism, phenomenology, and pragmatism (Yardley, 2017). IPA is characterized by phenomenology which was developed by Martin Heidegger being a student of Edmund Husserl. Husserl's approach was descriptive, while Heidegger emphasized that all experiences are related to people's backgrounds, and the experiences are evaluated in cultural, social and historical context. So that he underlined that meaning can solely be composed by person's experience and background (Klenke, 2016)

This method focuses on subjective experience and aims to make sense of interviewees' personal and social world. Work and workplace experiences related to bipolar disorder can vary across individuals, and experiences are unique. Therefore, description of experiences is the main aim of this research. IPA emphasizes the description of experiences and works to research similarities and differences in each circumstance (Smith & Osborne, 2007). In the current research, making sense of "the experience of being an employee with bipolar disorder" is the principal aim, and the themes, sub-themes, and master themes are searched in the dataset to depict the unique experience of being a white-collar employee with bipolar disorder in Turkey.

In the analysis process, first of all, the transcription of the data was rigorously red to get an overall sense of the interview. Secondly, each interview (starting from the first interview) was coded with sub-themes on MAXQDA. After finishing the sub-themes codes, central themes were created according to theme in which the sub-themes were appropriate. In this way main themes/titles were obtained. Lastly, an elimination was made according to which the headings obtained directly or indirectly served the central theme of work-life and bipolar disorder.

CHAPTER 3

RESULTS

3.1. THE REFLECTIONS OF SYMPTOMS OF MANIA IN THE WORKPLACE

We can examine the reflections of the mania period on work-life in two axes: “work-style” and “control of emotions” as Table 3.1 shows.

Table 3. 1. Mania in the workplace

	Codes
Work-Style	Productivity and Overwork
	Passionate working
	Compensation for underperformance during depressive period
Control of emotions	Grandiosity
	Impulsive behaviors
	Tolerance

3.1.1. Work-Style

3.1.1.1. Productivity and Overwork

When the participants are asked about the impact of the mania period on work-life, we saw that the discussion revolves around the theme of productivity and overwork as P6 answered: “I am becoming more productive.” We see that the participant makes a comparison with the period that she is stable, in remission, or depressive episode. Similarly, P10, comparing mania and depressive episodes, articulated the following sentences:

“In the mania, I wake up very well, I get up, I get ready, I go to work, I have good relations with people, and I go home peacefully in the evening with saying ‘I did my job well today.’ During mania, I am energizing; and feel more efficient, but when I got depressed with no desire to do anything because I come to

the point of being unable to settle down and keep up anything (*dikiş tutturamamak*)…."

P10 also emphasizes productivity in work-life as the positive aspect of the manic period. The participant is emphasizing some of the elements of the sense of well-being in professional life and shares that she has experienced these feelings during the mania. Sleep patterns, personal care, good relationships with colleagues, and job satisfaction are some of the themes that create a sense of well-being in professional area. Similarly, P6 adds the following experience for the mania, which is described as a "perfect period": "…By the way mania is a perfect period for me, because I have such energy. The mania is the term in which I can produce everything at the highest level. I think, I know how to make mania a little functional." When we asked P6 who associates the "perfect" manic period with productivity how she makes this period useful, she said:

> "If I have much energy and I can sleep less, I can do many things in the period. I guess I am not complaining by saying 'I am in a manic period right now'. I said to the doctor: 'I am in a good mood now, yes my brain is exhausting me too much; but I want to convert it to something useful. I could do many things, helping people and joining associations; maybe that is why I started ***XXX*** and voluntary work." (P6)

We see that the participant has not lost her insight. She stressed that many stuff fit into that period since the need for sleep lessens, and the energy increases, and these are the activities that turn the mania into a functional state. Apart from that, she says that she does not worry about the manic period and seeks ways to turn it into an advantage as the discourse of "not complaining about mania" highlights. Indeed, the "experience of exhaustion" that "the brain" causes, she gets tired, but she finds the strength to explore the ways to switch the difficulties of this period to productivity. The emotional themes such as "helpfulness" and "compassion" emerge in the expressions relevant to the tendency for overwork during manic periods. Then, is it possible to transfer compassion to voluntary work as the participant underpins?

Similarly, P2 says that he starts “to work like nuts”. When the tasks within the scope of his job description are done, the participant says that he helps others across the departments by “continuous rushing”. The “intolerance to be void of tasks,” is mentioned which is realized the next day as a “crazy day.”

“In the human resources department, if there are too many recruitment appointments, it can take the whole day; but if I do not have an interview, it means just a couple of files to edit, and when there are no tasks left, I go back-office activities like helping with the packaging. Since there is no departmental distinction in the office, I go from here to there, working like nuts. I realize next day that ‘I had a crazy time yesterday.’” (P2)

3.1.1.2. Passionate Working

We see that the participants mentioned working passionately during the manic period, which is a distinctive state even if this might undoubtedly be a usual action, but the participants reflected it as something unique to the manic period. The following discourse of P6 can be given as an example: “When I was in the manic period, I was in a period that loved my work incredibly and did it incredibly well.” A similar discourse arises in P7's expressions: “You cannot stand still in the mania. You want to have fun like crazy. If you are going to work, you want to do it like crazy; you do not get tired, you do not sleep, you keep moving.” The theme of passion that accompanies an overly energetic mood is also found in the P7’s previous citation. The desire to work with intense passion is one of the feelings that emerge during the manic period.

3.1.1.3. Compensation for Underperformance during Depressive Period

As we will see in the next theme, the depressive period appeared as a phase in which the motivation of the people decreased, and this affects the work-style. In this context, compensation of performance problems is experienced during mania:

“It (the performance) reaches the normal level. I am not making an effort to get through it. However, the decline in the depressive phase, for example, is like that *[indicating a low level with hand gestures*], then I bring it back here [*the level*

it is normally accepted]. There is no such thing as bringing it here [*a level higher than the line it is normally accepted*], raising it a bit higher. I was just making it a normal level again. I never put it on. I never tried to do even better. Anyway, if that is bad, that is bad, if that is good, that is normal." (P1)

P1 sees the manic episode as a chance to relieve the burden carried over from the depressive period to the manic period and the poor performance of the depressive period is compensated.

3.1.2. Regulation of Emotions

3.1.2.1. Grandiosity

Grandiosity, which is one of the symptoms of mania can be handled under the theme of exaggerated self-confidence in the context of professional life. How does this attitude affect professional life? During this period, P9 experienced a business initiative, she tells that:

> "I got the certificate in 2011; I went a two-week course. Then I set a company up in Germany. I was going to sell houses to people in Germany from here. So both in Germany and Turkey. At that time, I had excessive confidence; I imagined things that would not be as if I could. Normally it is a big step for a sick person, but at that time I felt like I was not sick. Then I set the firm up at the end of 2011. I came to Turkey in 2012; I rented a house in Antalya. I had already sold the house in Germany and I brought my stuff. So something big happened to me."

She shares that she had established a business with the attitude of "excessive self-confidence" and adds that she did not see that period as "abnormal" or "sick." It is questionable at this point that "feeling too good" is not perceived as an illness. We can say that this perception is likely to harm the person. Furthermore, at the end of this work, the participant said that the work she had set up failed. This failure may also bring about the possibility of a psychological collapse.

On the other hand, P9, who did not identify herself "sick" in this process, has an insight that her mood was related to the manic episode when she is in retrospect. We see this perception in the following dialogue:

"P9: I think I had an attack back then.

The interviewer: Is it depressive or mania?

P9: Mania, because I felt like a businesswoman."

The self-confidence nourishes "the feeling like a businesswoman", and the grandiose state by the clinical terminology emerges, and the participant later realizes that this was indeed a symptom of mania. In this respect, is the participant likely to make business-related risky decisions based on excessive self-confidence? Or can we talk about the possibility of developing the insight that she had an episode in order to prevent risky decision after the first episodes? Can the participant understand that it is an episode, take it under control, and minimize its effects? We see that people who have knowledge about their diagnosis and accept the diagnosis can perceive the symptoms and take precautions in order to prevent the episodes. For example, when the need for sleep reduces, when they feel too energetic, they may visit their psychiatrists to adjust the medications.

3.1.2.2. Impulsive Behavior

Impulsive behavior is one of the symptoms of mania. How do participants experience this in the work-life? P1's experience with colleagues reflects the mania impulsivity in work settings:

> "In the Mania, everyone is very happy, delightful. Sometimes when I have too much hyperactivity, for example, I hug, hold girls [*he describes that he attracts his colleague with his body language*]. She falls since you do more; it is at least twice than normally you would do. However, others say nothing; she laughs and stands up. 'Okay, I will not do it again', I say. I turn around and tease others. Then the atmosphere gets amusing." (P1)

He states that not only himself but also other people are more enjoyable, friendly, and happy during the mania period compared to the depressive phase. We can understand from the example that he cannot adjust the dose of jokes, including physical contact, from time to time. When he mentions the social environment has become more enjoyable, we see that his friends show tolerance or accompanied him. However, is this attitude acceptable in every organization? Alternatively, may his friends' tolerance in this process decrease over time?

P7 talks about the experience that we can consider in the context of impulsive behavior: "I do not want to work [*during the mania*]. I do not want to spend the day looking at a screen in a room, alone at a desk. I want to go out, I want to walk around." P7, who wanted to do other activities instead of working, found an excuse during the mania period and said that she went out and did the activities she wanted to do:

> "Of course I do not say that 'I am going to the beach to stay alone', or 'I am going to the Bosphorus Tour'. I say that I am going to the hospital, I am going to the doctor, I have some stuff, I am going to the bank etc. In the daytime, for example, I go out for an hour, sit in a cafe, drink tea and coffee and come back. 'Where did you go?' I went to the bank." (P7)

However, it should be noted that this participant works in the family business and reports directly to his brother and her manager who knows her diagnosis. On the other hand, despite these conditions, we see that she is not directly asking for free time off work; she uses other excuses to leave the workplace for a while; i.e., she does not feel the flexibility to control her time at work.

3.1.2.3.Tolerance

Some of the participants stated that when asked about the mania period, they did not feel any problems, everything was okay, and their tolerance towards the surroundings increased. When asked about the relationship between mania and work-life, P6 said "I have no problems during the mania. In other words, I do not remember having a problem." P1 shared that he was extra tolerant: "There is not much anger in mania. In mania, when one of my colleagues wants something, I can

say ‘never mind’ *(s….. e.*), we talk later’. I can be more tolerant.” Making a comparison with the depressive period, P1 emphasizes that there is no sense of anger and he “can give up”, “postpone” and “tolerate” in the mania compared to the depressive period. We see that the participants bring the emphasis on the manner so to say ‘no problem’, because they are delighted when they are in the mania period, and that even the frequency of visiting the doctor during the mania period is not high. However, the manic attack is usually confused with hypomania, which has milder symptoms of mania; therefore, the manic period defined as favorable might be indeed hypomania, instead of mania.

3.2. THE REFLECTIONS OF SYMPTOMS OF DEPRESSION IN THE WORKPLACE

The prominent themes of the depressive period appear on two axes. The first axis is “the communication difficulties” which contains the sub-themes entitled “refraining from communication”, “need for masking the mood”, and “unforeseen irritabilities”. The second axis is “changes in professional behavior” which incorporates sub-themes of “not putting in extra effort at work and impacts on professional behavior” and “unwillingness to go to the work and absenteeism.”

3.2.1. Communication Difficulties

3.2.1.1. Refraining from Communication

What kind of dilemmas can people with bipolar disorder face in work settings where interpersonal relations and communication are an essential component? How can the third people think if he or she does not know that the employee is in a depressive period? Is there any possibility of deterioration in the relationships? The citations under the theme of “refraining from communication” question these dilemmas that may occur in the work-life. The following segments from the interviews powerfully depict the emotions of our participants: “The fewer people, the better” (P1); “Because I cut myself off communication inevitably. It is such a problem” (P2),“Yes, I did not want to talk.” (P5), “You do not talk to anyone at work, you are too sad to say a word. You do not even want to go on the phone” (P7).

Participants interpreted refraining from communication with an emphasis on “abnormal behavior.”

> “For example, as you are normal, you suddenly become abnormal. If you are too talkative, you become withdrawn. So you do not even want to meet your close friends. They call, you do not want to pick up the phones when you see their calling. Here is my reason for that; I am unhappy, and I do not want to meet people when I am going to spread unhappiness; I still have the same opinion. However, friendship is good for all because they listen to you. But, again today, I would not call up either, I would not see them again” (P4).

Another critical point in the theme of communication is that although they avoid verbal communication, for example, as P7 states, they challenge by using alternative communication methods. For example, P7 avoids verbal communication and says: “I am mailing or communicating from WhatsApp with the customer.”

3.2.1.2. The Need for Masking the Mood

We see that they make an extra effort not to show their emotions and show an attitude towards masking and hiding. P2 said that “I am trying not to compromise my cheerfulness. Even if I minimize communication, I try not to interrupt it... If I hurt [*others*] in that period, I would be punished later. The people I annoy will be away from me”. When people are in depression, the burden of an inner struggle lets them show additional effort not to reflect their depressive feelings.

On the other hand, P4 said that “No, it *[depressive period]* did not affect the work-life very much. You are usually role-playing like in a stage”. While there is an intense internal depression, the efforts to conceal this are overwhelming. This “theatrical play,” which does not have many negative reflections in terms of its reflection on the other person and its effect on the work, is an experience that requires “intense emotional labor” from the individual.

3.2.1.3. Unforeseen Irritabilities

We see that P1 talking about sudden irritabilities:

> “For example, I have two friends in the graphics department. Something wrong is happening, I am walking over them. I call them for fighting, for ‘fling down a challenge’, such a rude manner... I am depressed that day, I already feel bad, and adverse thing happens at work. When someone tells me something, I flare-up. For example, I had someone with me, and he was a person I trusted. I asked him if my reaction was inappropriate. He said ‘Brother, you got annoyed unnecessarily’ so that I immediately apologized. They are usually younger than me, but I also go and apologize to them. Generally, these problems I experience occurred in the depressive period”. (P1)

The inability to control aggression can damage interpersonal relationships. The lack of behavioral consistency may also draw a picture of not ‘being reliable.’ Undoubtedly, all these risks and possibilities point out to the image that will occur if the person's diagnosis is not known.

Moreover, intolerance towards colleagues/workmates or working groups is experienced.

> “When I am in a depressive period, I feel like I am out of tolerance. Moreover, I work with children. I feel nervous. I think I am becoming an intolerable, unbearable person. I am trying to limit it as much as possible; because I work with children, the work requires consciousness, I try not to display to children. However, inside, I feel miserable, very nervous” (P6).

However, here again, we see that P6 makes an effort to hide his feelings or not to show it in some way as the inner distress continues.

3.2.2. Changes in Professional Behavior

3.2.2.1. Not Putting in Extra Effort and Impact on Professional Behavior

One of the prominent themes in the depressive period is the decrease in performance. It may also make sense to recall that the attempt to increase performance to the “required level” during the manic period is a struggle to compensate for the low performance in the depressive period. On the other hand,

these difficulties may not apply to all tasks. That is, while some tasks in the job description can be barely executed during the depressive period, some tasks can be performed more efficiently. P2 explains this as follows:

> "My only problem is; in this depressive period, if I was asked to conduct an interview with a candidate, doing the interview was challenging for me; it requires a focus on it [*kafayı toplamak*] so I may not be able to work very effectively, but my clerical work or things to be done on the internet are not ruined; they proceed".

The decrease in effort related to the performance in this period is also a critical finding. In this period, P5 stated "completing the requested tasks without taking any additional responsibility." With this emphasis, he highlighted his tendency to perform identified tasks without taking new roles and responsibilities. Considering that taking responsibility is one of the leading indicators of performance in professional life, it is a critical issue for people to do only the tasks asked by the managers.

3.2.2.2.Unwillingness to Go to the Work and Absenteeism

Another feeling experienced during the depressive period is the unwillingness to go to work. It is possible to emphasize that the loss of meaning and motivation, which is considered as one of the most prominent symptoms of the depressive period, may be related to this situation. For example, P10 gives an example of this: "There are two companies I worked with after my last hospitalization. I did not have much trouble with those two companies. Sorry, I experienced problems of unwilling to go to work, reluctance in the first company".

There is always the possibility that corporate culture or work content may create specific difficulties for individuals. A corporate culture that does not meet the expectations of the person and does not match the personality may create a reluctance to work. Or you may experience the same feeling when the nature of work does not fit individuals' personalities. But we see that the next citation is not a reluctance for such reasons, but a reluctance to work in general: "Otherwise, for example, he gets up very well in the morning. He said that he is going to work again,

he does not want to". (P4's sister) There are two emotions being a pleasant mood and reluctance.P4 feels pleasant mood before "the idea of going to the work did not come to his mind. However, when he faced the idea of going to work, reluctance occurred. It is also worth mentioning that there is a reluctance against directly to working because components of work and organization are not shown as a cause.

We see that the depressive period reduces motivation towards work. Another point is that there is also a loss of sense of responsibility which is one of the positive components of the person's relationship with the organization.P9 says: "I could not do anything about the job. I had a psychological breakdown. It is not mania; it is depression".

P10 mentions about absenteeism problem: "… Because a depressive period makes me losing my job. For example; if you do not go one day, two days; the situation can be a reason for dismissal".

3.3. OPINIONS AND EXPERIENCES ABOUT SHARING THE DIAGNOSIS IN THE WORK SETTINGS

The idea of sharing the diagnosis came up as a problem that the participants frequently raised and confused. The participants expressed many opinions about sharing or hiding the diagnosis. It is possible to see in detail in the following discourses and tables what kind of mechanisms affect in hiding or sharing the diagnosis (Table 3.2).

3.3.1. Disclosing the Diagnosis

The decision to share the diagnosis is made by the presence of either internal or external stimuli. In this context, we will examine the reason, content, and results of sharing under the categories of voluntary sharing and external factors.

Table 3. 2. Reasons for Disclosing the Diagnosis and its Content

	Voluntary sharing	**External factors**
Reasons for disclosing	- Concern for misunderstanding - A need to share difficulties - Disclosing following other colleagues' coming out related to their "concealable identities"	- Others questioning hospitalization and hospital visits - Being honest in the job placement interview
Content	- Medical attitude (comparison with physical illness) - Transfer of limit of intolerance and some compelling processes	- Emphasis on the treatment - Telling about medications

3.3.2. Voluntary Sharing

The managers or colleagues sometimes misinterpret some of the behaviors exhibited by the employees with bipolar disorder during the episodes. This is an additional burden for the participants. For example, in the depressive period, after refraining from communication with others; people should make an extra effort not only to recover from the period, but also fixing the relationships damaged during the episode. This burden carries the concern of misunderstandings too. Many people decide to share their diagnoses in order not to be misjudged and in fact through the need to be "correctly understood". In addition to being proactive decisions, sharing the diagnosis also has a reducing effect on the emotional burden of individuals.

For example, the following experience of P1:

> "Well, I disclose by starting with the proximal inner circle; but my parents, everyone, including my friends, told me not to share my diagnosis with anyone. I told them; 'I have to share this; if you have a problem with the lungs, you have to share it because one does not smoke with you, can you understand? When I have such a problem, he/she does not make an irrational act/behavior with me; because this behavior makes me annoyed [*tersime gelir*] at that moment, something can happen, so they know. I do not have

> an attitude that ‘I do not tell her, I do not tell him. Okay, I am sick, everyone is already sick… Okay, so we are taking medication. For example, there were people who had this problem, I told him that he had been living the same thing for five years, he was taking medication… He said; ‘I am like that.’ So what? Why did not you tell me before, are you an idiot?” (P1)

It can be said that the thought that triggers P1's disclosure about his disorder is the unusual (abnormal) behaviors that are showed during the episodes and to prevent misinterpretations by the people with whom he is in communication. By medical attitude, we see the analogy to the physical diseases. Another crucial point is the advice from his surroundings to conceal the disorder. How does this affect participants when they have internal conflicts about sharing in general and are so indecisive, that they get such a reaction after sharing? For example; can this be regarded as something that should be concealed, growing up the external or internal stigma?

As an example of a similar experience with P1 is the story of P3: “I shared with them. Because they were looking at me like I am crazy; I was getting angry, we were starting fighting suddenly with students.” Again, we see a concern for misunderstanding and the decision to share the diagnosis by thinking and acting on the other side. It is evident that the participant feels uncomfortable about being considered “insane” and also shares his diagnosis due to some of his unexpected/reactive/ impulsive behaviors. If we open this issue a little more; can we read that the patterns of behavior called “sudden or without any reason” are a discourse made with the intent of abnormal behaviors during the episode?

If we look at the decision of P2 to share, we see that it is formed around a similar concern and the idea of not breaking the relationship with the other party is dominant:

> “I prefer to share. We even had a meeting, the whole office gathered in a beautiful place at the beginning of the semester; an event like everyone should say something about himself/herself that no one else knows about. I said ‘Folks, I am bipolar, mind your steps. If I withdraw sometimes, it is

not related to you, I do not have a problem with you, do not take it personally'". (P2)

In this context, considering all these experiences; it may be appropriate to question whether the diagnosis is interfering with interpersonal relationships and communication, because the three participants share the diagnosis for protecting the relationship is not damaged and maintained.

P6 shares another experience: "One of my friends explained that she was bisexual while we shared our privacies in a conversation with my colleagues from the workplace. I said: 'does it matter? I am bipolar'. We had fun about these". Unlike other examples, the P6's experience of disclosing has evolved in a process that begins with revealing other "concealable identities." The emphasis on "does it matter?" creates a context that individual differences (characteristics that may be deemed by society) should be treated naturally; it creates a trust-based presupposition among those whom this sharing; bipolar diagnosis is also shared as a natural condition. We can say that the participant exhibited an assertive behavior in sharing her diagnosis.

We can also understand that the reason for sharing P6 in another workplace is the need to share her experienced difficulties: "My close friends knew there. I shared some of the difficulties I had. I experienced things like this, I am on the line of intolerance nowadays, it seems to me too much ... But I do not usually share". It can be read that, due to the difficulties caused by too much harm to herself and the need to share them with someone else. The participant may have hoped that this conversation would be expected to be understood from the other side, alleviating her painful experiences by conveying that she was on the edge of intolerance and that his experiences were too much for her.

P5 told us that after sharing, his friends did not care very much, but they made a joke in a gentle way:

"Then, I mentioned it (bipolar disorder) in my work-life. There is no knowledge about bipolar disorder; none in the community, no one, almost no one. What is this illness, how does it affect people or how to

communicate with people who have this illness? Everything is normal and people are trying to maintain their lives as if these experiences are mundane. Sometimes it can be a kind joke". (P5)

P5 emphasizes that there is no information about bipolar disorder in the perception of people in the community and conveys that he encounters sarcasm in a gentle way. He also adds that he is uncomfortable with his colleagues' non-critical perception of everything as presented, and in fact, his approach to bipolar disorder is in this way. We can say that the participant feels uncomfortable not to be taken a sensitive approach to bipolar disorder.

What kind of reactions did the participants encounter after sharing? P2's experience is as follows; He begins by stating that he has not received any positive or negative feedback from his environment and: "No, I did not get any feedback because I do not think that I reflect or express this too much. I am trying not to compromise my cheerfulness. Even though I minimize communication, I try not to interrupt it".

P1, P3, and P6 reported that they faced supportive attitudes. For example; P1 said that his manager does not create problems when he is late:

> "He said that it would be such things, we're satisfied and happy with you. Let's do it properly without exaggeration. God bless him; he never did anything. Sometimes I went late; sometimes I said I cannot come today. He never did anything about that". (P1)

When P3 sometimes felt not well, and when his anger was by fellow teachers, they let him rested him a little:

> "I mean, I do not know what to say, when I get angry, they say 'you get some rest, and we may substitute you over the lecture.' Or when there is something different, they say suggest to intervene. Or when I raise my voice, they come running, trying to soothe, trying to tolerate". (P3)

P6 said that even in the state of slight level of unhappiness, her colleagues supported her: "Their attitudes have not changed towards me actually. Even when

I was unhappy, they became more supportive. Even if I am not in a depressive period, I've had unhappiness".

On the other hand, P3 has also experienced:

> "I think it was good, but if they (teachers or other employees) wouldn't have told the students. Here the manager told, I was down; I was in the workshop. There was the manager's room upstairs. I heard it from there. I heard the manager said 'what should I do, he has got a problem'". (P3)

Feeling well after sharing the diagnosis, P3 said he was uncomfortable with his manager telling someone else: "Students betray it if they know. So they use it for good or abuse. They abuse more". P3, who teaches, says that he does not welcome his manager to uncover his diagnosis to a student without his personal consent and that he is worried that the students will use it badly.

Periodic hospital visits during the treatment process of P5 was a factor that led to explain the diagnosis. When we look at the participant's opinion about sharing the diagnosis in general, as we will see in the next section, he has an opinion that is not very close to sharing the diagnosis. Participant's sharing experience is as follows:

> "I had to go to the hospital for pharmacotherapy. I did not feel any concern for not sharing the reason anymore because it was an illness, it was a livable illness, it only affected the quality of life, and there were medicines for regulating it, so I made that process at least certain". (P5)

The participant's cause to share his diagnosis was to explain the reason for his hospital visits because he pursues pharmacotherapy. When explaining the diagnosis, they have an assumption that most people are unconscious. Therefore the emphasis on the treatment for the diagnosis and maintaining daily life could be an attempt to reform their perception.

In some points, P9 quoted a similar experience: "Of course, when you've been sick for a long time, your friends ask, 'What's wrong?' I was saying it was a psychological problem". P9 is also a participant who makes some internal

questioning about sharing the diagnosis in general and does not prefer to share the diagnosis, but she has to disclose with the constant questioning of the employees.

3.3.3. Hiding the Diagnosis

Apart from their experiences or opinions about sharing the diagnosis, we found that they have some opinions about hiding the diagnosis. If we examine the confusion or conflicts of thought mentioned above regarding the sharing of diagnoses with the segments about hiding the diagnosis, we will depict a clearer picture. Detailed information about the concealment of the diagnosis is given in Table 3.3.

Table 3. 3. Hiding the Diagnosis

	Organizational Factors	**Personal/Relational Factors**
Reasons for Hiding	- An attitude of the manager - A concern of dismissal from the employment - Organizational culture - Work that is not done with pleasure - Errors associated with the diagnosis	- Unconsciousness - A concern of interfering to the private space and questioning - Trust relationship - Emotional reactions
Content	- A distinction of the superior and subordinate position - Colleagues trying to find mistakes - A distinction of corporate and start-up culture - Not want to lose the job - Association of non-performing tasks with the diagnosis	- Education level, bias, the attitude of the media and marginalization - Questioning even if superficial answers are given - Lack of closeness - Pity and apprehension

We will examine the participants' concerns regarding the concealment of the diagnosis under two main titles: organizational, and personal/relational factors.

3.3.3.1. Organizational Factors

Under this title, we will focus on the hiding decision of participants around themes such as their work, teammates, and corporate culture.

P8's idea of not disclosing the disorder with the managers provides a clue about managerial attitudes and there is a questionable discourse: “But, especially, I try not to tell my superiors at my workplaces. I have talked to my subordinates or other people who are in a similar position with me at work or another department”. P10 is worried about losing the job with the following words: “No, not. I cannot tell, because if someone hears it, I am going to end my work by myself. Because people are gossipers and people are looking for finding others’ mistakes”.

Predictably, a participant who thinks that hearing the diagnosis in the work environment may result in dismissal from the employment can be caused by the experiences of the participant. As mentioned in the previous chapters, P10 was fired from the workplace where it had her first episode. Another point is that should be emphasized in this regard is that; in the work environment, people try to look for each other's deficits, and bipolar disorder is perceived as a factor for ending work. It is also essential to discuss that these experiences in organizations are likely to cause devastating effects and destruction in the emotional world of individuals.

P2 tends to share the diagnosis based on corporate culture: “If I go to a corporate place… Never… I prefer to stay in start-ups, because in this organizational culture, you are not meant to lose your personality. This is my personality”. This gives evidence that he can disclose in start-up companies but has to keep it hidden in companies called “corporate structure”. This is attributed to the fact that it is not odd to work with your own identity/personality in start-up companies since he connects the philosophy of start-up companies. If we discuss the definition of authentic behavior here, can we also comment that corporate culture does not accept it?

P4 says he prefers to hide it because he does not like his work: “If I had a normal job, a job that I did willingly and I did not want to lose, I would say everything as it is.”

What is the effect of sharing the diagnosis with or without liking? At this point, it may affect the fact that one feels confident in work done, and could this confident be formed in the soundness of his / her competence and equipment? If we open a little more; he is already successful in a job he likes and does this guarantee that he will not lose his job or face any other difficulties under the condition of disclosure?

P5's concern about to be related to the diagnosis and made mistakes can be given as an example of stigma: “Anything you cannot do will be linked on this label.” In this context, it is difficult to comment on whether it is internalized or external stigma because the participant may have acquired such an experience by indirectly observing it. However, if we start a discussion with the following question: why does the participant not close to the idea that when he makes a mistake, he does not have enough equipment, or that anyone can make a mistake, but he thinks that people around him can relate to mistakes with the diagnosis?

3.3.3.2. Personal/Relational Factors

Apart from organizational factors, we will look at people's personal views about hiding the diagnosis in the organizations, and what are the relational components along with the presence of a second person who influences this personal decision.

Thinking that people, in general, are unconscious about the diagnosis; is this a factor affecting the decision of hiding? For example, if we look at P4's discourse that associates unconsciousness with the level of education: “But I do not have the thing like that; you can share with educated people, of course.”

P5 finds concealment more accurate in terms of prejudice and negative images created by the media and society:

> “People always have a prejudice against everything. What does the sharing add to you plus or minus? We need to find the answer to this question. If you do not work with disabled staff, if you are working in a regular status, there is nothing to share. It has no added value for you because you will only

> expose yourself where there is no awareness and knowledge of it. You get adverse perceptions because people know bipolar mood from television serials. They know a few headlines so that their reaction will be negative".

P5 wants to hide the diagnosis because of the attitude of the organs in the media about bipolar disorder. If we elaborate this discourse a little more; Newspaper headlines that link the news with violence and serial figures revealing as stereotypes and misrepresentations shape the perception of the society, and therefore, they prefer keeping hidden.

P10 has a similar concern with P5 and says: "Not only bipolar disorder. In other words, immediately crazy and maniac come to mind when you talk about mental illness. There are disdain and marginalization". We see that the factor affecting the hiding is based on a social label for mental disorders in general. Society's use of the word "crazy" with equipped adverse effects and its condescending attitude makes the participant hide. P10 also states that people keep the diagnosis hidden because the participants are afraid that they will question it too much when the diagnosis is shared, and they will interfere with the personal/private space:

> "People are also interested in seeing something different. They are starting to question. When you say something, if you give a superficial answer, it immediately attracts their attention, this time they question. They are starting to ask questions. As I escaped this time, he is doing something more and saying there is something". (P10)

When the disclosure decision is taken, having the possibility of interfering with the private or personal space of the participants, asking too many questions and tampering by the others are led to hide. What can be the impact of these attitudes (privacy being questioned so far) on individuals diagnosed with bipolar disorder?

From time to time, P6 shared with some people. The factor affecting her confidentiality is the lack of trust. She prefers to hide from people whom she has not yet developed closeness: "Yeah. The people at XYZ do not know either because

I am new at XYZ. I have been there for a month. So I could not establish a close relationship with anybody".

Emotional reactions of individuals also affect the participants' decision to sharing of diagnosis: "Other than that, I do not like to share much, I do not prefer because people directly show pity or apprehension because they do not know." (P6)

Emotional reactions, especially apprehension and pity, make them abstention. Both of these reactions can be said to be related to stigma. Apprehension describes a person (with bipolar disorder)'s potential for harm, while pity refers to a person's hierarchical level of social interaction. When two people are socializing, the individual reacting pity emotions, positions the other person in the lower position. These behaviors, which are frequently encountered in daily life, affect individuals with bipolar disorder socially and position them at the lower level in the social hierarchy. Apprehension and pity contain exclusion in common.

P9 quotes about hiding the diagnosis and opens a different door for taking a hiding decision: "I am trying to conceal my illness, and it is getting more and more tired."

We can say that the effort of trying to hide the diagnosis is an exhausting effect on the participant. The need for transferring this fatigue to the other party can be read as a reference to organizing constructive relationships in the work-life. We mentioned that other participants experienced relief after sharing. Based on the referring exhausting effect of hiding, would P9 experience a sense of alleviation if she shares it? However, all these constructive and destructive effects contain many parameters. Maybe she can get more negative feedback from people. What should be emphasized is that; the participant is experiencing fatigue caused by her concealment.

As can be seen from Table 3.3., the factors that affect the concealment of the diagnosis are as diverse as possible. However, it has one thing in common: there are many assumptions about the perception of the other side in the perception of the participants. Fear of exclusion is the most potent factor affecting this assumption.

3.3.3.3. Consequences of Sharing the Diagnosis and the Need of Detailed Definition of Bipolar Disorder

P10 experienced an episode at the previous workplace, so she had to explain the diagnosis because of hospitalization, and as a result, she was dismissed. The participant said that she had successfully passed all the processes later in a job interview, but could not get the job because they learned about her diagnosis when they called the former workplace for a reference check. The reaction of the organization was: "They became angry and said that: 'You have experienced such a situation; you did not tell us, why did not you tell us?'". Not to be accepted to the job due to not being honest enough led P10 to share the diagnosis in the next job interviews. While the person was going to get a third job interview (indeed first working day), when she took a health report at the workplace, she told the workplace doctor about the drugs she used and the diagnosis. When P10 shared the diagnosis, she had a dialogue with the workplace physician as follows:

> "He said I would meet with the human resources department and come back. He has gone, it has been an hour, it has been two hours. It was noon. I was waiting for information and response. They let everyone (recent beginners) in. After that time passed, I went to the human resources department; 'I am waiting for a response from the doctor; did anything happen? What happened?', 'We cannot decide for you right now. We need to meet with the top management. Then we will give you the information. You can go home.' One of my grandmother's neighbors was someone with a broad circle of textiles. She knew the owner or his son. She called there and said; 'We have a daughter, she is going to get a job, she cannot get results, what happened?' The doctor had given feedback to the boss: 'This person is dangerous because she uses the medication for schizophrenic patients. She has the potential to disrupt the work and cause trouble, so I disapprove.'". (P10)

P10's first episode at work caused her to be terminated from her job, and in a job interview, sharing her diagnosis resulted in her refusal to accept work. Since the participant was not honest enough, she decided to share her diagnosis after receiving a rejection from the previous job interview, and this also led to a rejection.

The marking of the person as a potentially distressing person is a glaring example of external stigma.

Sharing with colleagues, P7 says she feels compelled to make a detailed statement:

> "And now when you say to people bipolar in the first step… People do not know about bipolar disorder. First of all, you have to explain this to them. You have to explain this to each person whom you share. The bipolar patient is not crazy, is not a 'mentally-ill patient.' The bipolar patient is a patient with a mood balance disorder, and the doctors bring the balance with the drugs. You have to explain it, you need it, or else in your slightest thing (behavior); "Oh, this is insane!". Unfortunately, people are very ignorant about it; they do not know. In fact, people are not very conscious about bipolar, even though there are too many bipolar patients".

P7 complaining about the unconsciousness of the people underlines that she feels obliged to make a detailed explanation in order not to get the "mentally ill" stigma in the case of the slightest errors, "inappropriate" action or any other action that can be a potential to be marked.

After the sharing of bipolar disorder, people's feelings of "pity" are included in P9's transmissions: "I felt like they were looking by pity to me. Maybe, I feel it, I do not know". How does pity affect individuals with bipolar disorder? Can the looking by the pity be interpreted as a stigma or as a means of reinforcing the internalized stigma that people apply to themselves?

Table 3.4. allows us to see the interrelation of the themes we describe in this section. Table 3.4. includes the decision to share the diagnosis of individuals due to their wishes and external factors, the reason for sharing, what elements they refer to when sharing the diagnosis and the reactions they face after sharing. In this way, it provides a more accurate view of the similarities and contradictions between the voluntary sharing and sharing made due to external factors.

Table 3. 4. Reactions of Sharing the Diagnosis

	Voluntary sharing	**External factors**
Reactions after the Sharing	- Not to take negative reactions - Someone who is shared with, to tell someone else - Supportive attitude	- Pity - Joke - Dismissal - To be rejected for a job

3.4. DIFFICULTIES IN WORK-LIFE

When we examined the participants' difficulties in work-life without necessarily dichotomizing them specifically to depressive or manic episodes, they converged under two master themes (Table 3.5.): personal/interpersonal and organizational/work-related difficulties.

3.4.1. Personal and Interpersonal Difficulties

Participants' diverse experiences, on a personal extent, would be useful to draw up the spectrum of the unique effects of disorder on the work-life of individuals with bipolar diagnoses. At the same time, we have seen that some of the personal challenges that we call “personal” create difficulties in interpersonal relationships. For this reason, some of the sub-codes create difficulties only in one's inner world, while others bring difficulties in maintaining interpersonal relationships.

3.4.1.1. Difficulties Caused by Diagnosis and Treatment

We saw that both the symptoms of the diagnosis during the episodes and the responsibilities have to be handled during remission periods lead to various difficulties.

Table 3. 5. Difficulties in Work-Life

Personal / Interpersonal Difficulties	**Organizational / Work-related Difficulties**
Difficulties arising from the diagnosis and treatment (failure to work during episodes, side effects of the medication, difficulty in coping with anxiety and stress, alcohol, substance use, and sleep disorders)	Working hours and workload
Impairment of impulse control	Physical conditions (noise, workplace and weather conditions)
Emotional difficulties (crying, internal conflicts, stress, the feeling of failure and inefficacy, reluctance, boredom, and intolerance)	Difficulties in adapting to the culture of the organization and commitment to the organization
Disagreeableness and conflict	

3.4.1.2. Inability to Work during the Episodes

Not being able to work during the episodes is one of the most crucial difficulties, as P9 points out:

> "First I went to a private doctor. That doctor was also in charge of Cerrahpaşa. I went there. There I got a sick leave for 5-6 weeks. I hardly got it, by the way. The doctor told me that 'If you cannot work, quit the work.' I dropped it to part-time. Then I could not bear part-time either". (P9)

We see participant's effort to continue working part-time during the episodes, she has a desire to work. However, after a while she was unable to work.

On the other hand, P9 expresses the anxiety of dismissal and the feeling to be monitored by other employees: “But since I started to get a sick leave frequently, I started feeling reserved/withdrawn *[çekingenlik başladı];* I was afraid that my employer would dismiss me. I felt like I was monitored at work. I thought I was being watched”. While the participant expresses her state as “being reserved or withdrawn” because of the sick leaves she utilizes during bipolar attacks, she starts showing avoidance from work through the accompanying feelings of “respect, fear, and withdrawn.” The participant's discomfort in getting a report and the accompanying dismissal anxiety were associated with the diagnosis; because the participant reports that this is a feeling that developed after she mainly started getting sick leaves.

3.4.1.3. Side Effects of the Medicine

The reflections of the side effects of medicines on work-life are related to the capacity to “remember”, “understand”, and “learn”.

We know that some of the medications are specific for the episodes or remissions. For example; medications during the acute period are used for the relapse of attacks, and medications during the remission are used to prevent a recurrence. The effects and side effects of these medications vary across the individuals, and their work style is affected by diversely too. For example; P8 shared this experience:

> “For example, sometimes my supervisor tells me, ‘Do it like this’. I am getting feedback and start to interpret by recognizing that ‘It is so straightforward, how could not I catch it?’ However, I used to do these things very comfortably. ‘How can not I think of that?’ I have experienced this as a difficulty at work during periods of medication”.

We may think that the problem arises from the comparison between the use of medication and before that term. The fact that an idea that someone has said, guided, or recommended does not come to the mind of the participant is a situation that may cause trouble for him.

In terms of medication-related difficulties, P9's experience in comprehension is reasoned by drug side effects is as follows:

> "The interviewer: What other troubles do you experience in your work-life?
>
> P9: I feel like they would discover my illness. I have a fear of being uncovered and I do not want it.
>
> The interviewer: Why do you think that they would discover your illness, because of your behaviors?
>
> P9: For instance, sometimes, I do not understand what they say. Then it sounds like they would notice *[my disadvantage]".*

We see that the participant has a concern about her disorder getting uncovered by colleagues due to the side effects of the medication that causes a cognitive deficit in comprehending, for instance, hardship in verbal communication.

P10 conveys a similar experience:

> "*[In the process of job application]* Even though I somehow passed the interview, when I started to work - how do I say it? A person changes from one moment to the next… And for me, I am like a machine or robot with the effect of drugs. I mean, my movements are dull, I stare like I do not understand anything. They say, idiots, I mean, it was so close that I was almost catching such a label. This made me very sad because when I was in the hospital, the idea of "I have a job, so I can do it, and I can recover" was empowering me. Encountering these pitfalls saddens me following being discharged from the hospital".

We see that P10, which is one of the discourses used by many people in pharmacotherapy, talks about the "feeling like a robot" because of the medicines, and the hardship in understanding. Another critical point here is the therapeutic and supportive effect of the work, even imagining that she will be back to work was

helpful for recovery during hospitalization. Being employed, having a job, and the possibility of returning to work strengthens self-efficacy; however, the side effects of drugs damage employees' feeling empowered at the real-life work setting. When they talked about the positive aspects of the work, when we asked about the effect on their illness, we got the following answers: "I do not even want to get out of bed when there is no workday" (P2), the work is terrible and the conditions are adverse, but at least I've started there to recover myself a little bit more" (P5), "I think it is positive. It positively affects" (P6), "Of course, it is good for everyone" (P8), and "Working is good for me" (P10). In summary, the healing effect of the work on the diagnosis is an experience that the participants realize.

P9 also shares her experience of difficulty in learning during her on the job training to work in the call center, which is illustrating her "learning disability": "The training lasted six weeks. I had a hard time there. There, I felt like I was not able to learn; I had a hard time learning. Sure, the others are younger than me; they were learning quickly, I was struggling".

3.4.1.4. Having Difficulty Coping with Anxiety and Stress

P5 talks about ups and downs in work-life and mentions the inability to know how to cope with anxiety and stress:

> "My work-life has been fluctuating depending on my illness. I had to change a few jobs and had serious difficulties. Anxiety was the most fundamental of them. I have always had problems when I work under intense stress, or I did not know how to absorb and deal with stress. This reflected in my private life. Therefore, I am having serious difficulties. I haven't worked for two months now".

We see that P5 has anxiety when working under stress in the work-life. He also stresses that anxiety is the most challenging experience he has had. We also see that anxiety leads to the deterioration of the balance between work and private life. We understand that anxiety caused him to leave jobs: "The reasons were the difficulties *[and changes]* I had in work-life. Each change was a problem caused by the concerns and fears I raised within itself" (P5).

We know that change is something that can be experienced in every aspect of our lives. In organizations and business life, change in the culture, policies, the business conducts, or other components is a usual experience. The anxiety and stress of P5 are also one of the emotional reactions that many employees may show during any change in organizational settings, but in the case of P5 as an individual with bipolar disorder, the uncertainty brought by the change leads him to quit the job since stress level is perceived unmanageable.

3.4.1.5. Alcohol-Substance Use and Sleep Disorders

The performance decreases due to the disturbance of sleep patterns accompanying the depressive period and sometimes with the use of pleasure-inducing substances.

> "During that depressive period, my sleep pattern gets already disturbed. For example, I need to get up at 8:00 a.m. to get ready and be at work at 9.00. I am going to work late because I wake up late. I do not sleep till 03.00 a.m., 04.00 a.m., because XXX [referring to the substance used] makes me very high. I drink, drink and drink until morning. When I am at work; my performance deteriorates to a large extent. I fell asleep too many times at the office" (P1).

As we see in the case of P1 alcohol and substance use are also encountered in people diagnosed with bipolar disorder. How does alcohol and substance use affect work-life? It is worth looking at this experience that P1 shares when he talks about the effects of sleep problems on work. P1 states that he has been asleep at work and has fallen asleep as a result of alcohol and substance abuse.

> "What triggers my insomnia… Why am I sleepless? I do not drink alcohol regularly, but when I taste it, I keep drinking… But the next day, of course, I have a regret, both physically and mentally. There are things that make me sleepless; I am manic, I am traveling and having fun; I am depressed, I cannot go out. Did you understand? The consequence is falling asleep, at work".

3.4.1.6. Impairment of Impulse Control

We see that people diagnosed with bipolar disorder experience impulse problems due to various triggers in the work-life. For example P3 who is a teacher at the high school said: “Of course, of course, anger bursts. I mean, I was walking to one of the workshops at the school, someone said, ‘Look P3 is coming’. I reacted by asking, ‘What are you saying?’ So anger erupts.” P3 conveyed that he had succumbed to his anger at the tone to be ridiculed. However, as he says:

> “This is not blowing up from nothing. I mean, I was getting angry, I do not know, there was something that made me angry. Why should I get angry without any reason? Why should a person get angry without any reason? There was something that made me nervous”. (P3)

Could a person without bipolar disorder control the anger under the same conditions? Or could the students behave to a teacher who does not have a bipolar diagnosis? In an impulsive experience such as an outburst, we should say that the disrespectful, humiliating or stigmatizing attitudes in the social and organizational environment towards people with bipolar disorder are determinants.

From time to time more severe reactions can be displayed: “The student was wrong to me. He was sharp. I could not stand it, so I had to fight physically with a student. I got angry, I grappled with the student” (P3). P3 firstly mentioned his efforts to control himself when the students ridiculed him and teased him; he warned them and requested to stop. As they continued to do so which can be considered a form of upstream psychological violence form students to a teacher, P3 lost control and showed physical violence. First, we see that P3 tries the compromise and tries to reconcile, but the other party continues the provocative attitude so that P3 loses control and act impulsively. The same participant also describes his conflict with his colleague, as reaching the level of physical violence, too:

> “He was my manager. He corrected someone else's weekly schedule and broke my schedule. So my syllabus was changed without my consent. I said, ‘why are you doing this? ’ I tore the program. We started to grapple. He did not grapple, I did, I started the struggle. We fought on the ground literally among the students. Once, again I was on surveillance duty at the campus, one student opposed me. I just got mad. I started fighting with him on the floor among the others. I mean, I fought the student on the floor in public in the garden. This is something inappropriate for the teachers. So this was indeed a big thing” (P3).

Unable to control himself against unfair practices, P3 says he tries to talk again first; when nothing has changed, we see that the situation evolved into physical violence as a consequence of impulsivity. A similar thing happened with another student. However, P3 is aware of the fact that this situation is inappropriate for a teacher and that this behavior is problematic. P3 explains his emotional reactions as caused by his depression which was misdiagnosed as a unipolar major depression: “I have used antidepressants for years. I used antidepressants until 2012”. He also changed the psychiatrists a lot: “I did not believe that he/she helped me. I was constantly changing”. This is a strong example that underlines the importance of correct diagnosis and treatment.

In P3's experience, to be ridiculed in the work environment, unfair decisions of managers, or unsupportive attitudes toward employees’ demands depict a “toxic work environment”. It can create anger not only for people with bipolar disorder but for anyone without psychological health problems. The difference is the exposure to such an unhealthy work setting for someone who is in the process of treatment or who has not yet benefited from adequate treatment. Naturally, anger control is even more difficult for this person. As a result, we see reactions that professional life cannot accept. This experience is, in fact, an excellent example to portray the interaction of environment and individual characteristics.

3.4.1.7. Emotional Difficulties

The data brought out sub-themes of crying, internal conflicts, stress, feeling of failure and inefficacy, reluctance, boredom, and intolerance emerged to compile under the master theme of emotional difficulties.

3.4.1.7.1. Crying

Being in the work-life, on the one hand, and experiencing emotional difficulties, on the other hand, could cause inner conflict. For example, P9's discourse is an example of how challenging from an emotional point of view: “I was always crying at the workplace.” We see crying as the expression of intense grief. Which reactions did the participant encounter when she cries in a professional setting? How does this affect others in that social setting? Have they developed reactions such as being indifferent or supportive? P9 mentioned the supportive attitude of the manager: “He looked like that [*supportive*]. They [*her manager and coworkers*] could think that I can be in trouble or something happened to me”. (P9), but her colleagues: “were looking with pity” (P9).

3.4.1.7.2. Inner Conflicts

Apart from crying, another sub-theme on the emotional level was the inner conflicts as experienced by P2 and P7:

> “I cannot make friends, I cannot communicate. I mean, I prefer to work alone, if the other person is not very friendly and positive. I mean, when I got into the job, I experienced this so clearly. Because working was a huge fear for me. I did not know what kind of environment to work in. The place where I work now is a start-up so it has a very flexible atmosphere. I can establish healthy relationships with people because it has a comfortable climate. I was enjoying it when I started. It was a great pleasure for me to come to work… I have a job now, I got into work life, I am thrilled to say that I am in a pleasant environment, I was very energetic. But, then I began experiencing internal conflicts, inevitable “shut down”. As people go out to

> smoking, *[they invited]:* 'Do you want to come?'… 'No, I cannot right now, I have tasks to finish.' After doing this three to five times, people stop communicating unless they have work-related issues. We are okay, we have no problems, no quarrels, no tension, but they do not want to accept me in their social circle". (P2)

The communication was one of the major themes related to difficulties, especially during the depressive period. P2's "internal conflict" discourse tells us about the emotional background of the difficulty in communicating. The participant experienced internal conflicts across the work, which he loved so much that he worked with high motivation, but suddenly start to withdraw from social interactions, which was probably an unexpected response for others too.

In the previous quote; after questioning during the interview whether the participant received any feedback on this issue which is not to be invited to do something collectively, or whether his feelings were in this direction, he replied:

> "I did not get feedback from them because I was really feeling bad at that time. Last Ramadan period, the period corresponding to the 15th of June; at that time, on the one hand, I had to work, on the other hand, I was making such plans of jumping over the bridge, or cutting my wrist, and preoccupations with getting overdose self-medication, and potential consequences like stomach pumped, and so on. I was in a bad mood, but I was not sure if it was reflected in a different way to the others. Maybe it was reflected as if I did not want to meet them, and I did not enjoy being with them. Somehow my communication was broken" (P2).

As the individual was struggling in adverse inner experiences, the communication with others was broken, who did not provide any feedback on this process to P2. As he was under the strain of suicidal thoughts, P2 emphasizes that the others were not satisfied with him, and he feels like being socially unfavorable. This reserved manner experienced during the depressive period creates a detrimental effect on interpersonal relations. What if his emotional state was known

to be temporary, i.e., known to be an episodic symptom, the reactions from others would have been changing?

3.4.1.7.3. Vulnerability

There is a constant emphasis on the vulnerability of people with bipolar disorder towards work stress and despair that P5 highlights:

> "In other words, there are always problems in work settings. The crucial thing is how much you overcome these problems. Maybe everyone faces the same problems, but idiosyncratic reactions are critical. People with bipolar disorder are vulnerable; they feel helpless if they cannot solve the problems and got hurt. At least I am" (P5).

First of all, the participant mentioned that organizational settings bring various problems that make people respond by various emotions, however, the same situation may induce different emotions in different people. P5 thinks that people with bipolar disorder are more susceptible to problems that they cannot solve. He emphasizes that this feeling is also backbreaking.

3.4.1.7.4. The Feeling of Failure and Inefficacy

Another emotional difficulty is the feeling of failure/inefficacy. As "the reason for quitting the job", P5's following answer sets an example of these feelings: "I felt like I failed at work. I felt I was not competent". It is primarily questionable how the participant, who has been doing the same profession for many years, received awards and promotions for his achievements, feels this way. When elaborated, he added:

> "So I know I would fail if I try to work on fields that I am not considered qualified or I do not have competency. Indeed, I am obsessing that I am failing, and this scares me. This fear, anxiety makes me uneasy in terms of communication. So my level of capacity to work gets low. But I overcame this with the medications. I am a little more comfortable now". (P5)

Both probabilities of being perceived incompetent by others as negative social perception and the negative self-evaluation as the segment of “I do not have competency” highlights generate fear of failure and generates withdrawal from interpersonal relationships at work. In both cases, we can say that the participant is worried about failure when he is out of his expertise area. Concerns about non-specialist subjects are often considered natural; however, the fact that this has a disastrous effect on the person's working life, discontinuing effort due to the feeling of inadequacy, and obsessing with the possibility of “failure” trigger other problems. The participant associates this with communication problems. However, his insight into the effectiveness of pharmacotherapy to overcome these feelings is essential. Of course, being competent in everything, being keen to overcome all struggles, and living in “the ideal of perfection” is not realistic. How can we interpret the decision to quit a job after ignorable failures or errors? The inability to tolerate failures and feeling incompetent in a small crack is a rough experience that devastates bipolar people’s sustainability at work-life.

P9 conveys this feeling as follows:

> “I got into the trade fairs business last year. They were opening a stand. I worked there for a week. Then I quitted by thinking that I could not make it. I do not know, there are always negative thoughts in my brain, they say to me: ‘You cannot succeed, you cannot do it, leave this job.’ I always struggle with these thoughts. Maybe I could have succeeded”.

We see that P9’s reason for leaving the job emerges as “the obsession with potential failures”, and she grounded her “fear of not being successful at work” in “negative thoughts in her brain”. Struggling continuously with these thoughts refers to internal conflicts. In the last expression of “Maybe I could have succeeded” underpins the fact that she perceives her earlier self-evaluations unrealistic. Maybe she is competent, and she has the psychological capital to succeed, the negative thoughts of “cannot” is burdensome.

3.4.1.7.5. Disagreeableness and Conflict

Interpersonal disagreement is an issue that we face in every aspect of social life. The theme of conflict and disagreeableness was highlighted for employees with bipolar disorder.

The following dialogue with P1 sets an example:

> "The interviewer: Initially you said, "my relations with objects are better than my relations with people". Could you elaborate on this?
>
> P1: If you want to do fashion photography, you have to contact the person you will shoot. So if you are photographing a woman there, you should manage that process adequately; woman's hair will be made; you have to develop excellent communication with the coiffeur in order to let the woman's hair done beautifully. The woman's make-up should be like that too. You have to motivate that woman for photo shooting. That is what I mention as a person and an object… I will be on my own *[if I am not photographing people]*, they will tell me that these objects are going to be shot, that way. I sit, I do it all night, I try, I do. So working alone; not in a very collective, but on my own… Let me have my equipment, my cigarette, my tea, let me sit down and do it. In the former task, I have to develop a good dialogue with five or six people so that the work will be done correctly. So I believe I cannot manage these mundane tasks, so I do not enter that field. That is why it is always objects, inanimate things... After all, you have to choose a branch. If you say I shoot it, I shoot it… You are a physician, which specialty? Well, we are looking at the stomach, we are looking at the brain or something? Like him, I chose my specialty".

Since interpersonal communication is one of the essential requirements of his job; the participant's obligation to communicate with many people has the potential to create a problem. Furthermore, he adds that he does not possess the skill of constructive communication and the situation creates troubles for him. Communication with people and finding appropriate jargon ("I need to have a good

dialogue") are challenging factors. That is why he says that he prefers working objects instead of people.

P1 is also experiencing another conflict that develops as follows:

> "It makes me nervous when somebody who does not know my job commenting on the work. It was the first thing I ever had in *XXX*. We had a manager, let us say there are 30 of us. There is also an online [*another department*] staff of three people. The first problem I had with them. I know the task can not be handled like that. As with any work, there are some rules. They say 'If it does not stand there, let it put there or something…' Do not push! Its place is here. Then they keep forcing, "Okay, shall we put it there?". The first conflict began there. I said, 'This is the way it is.' When I worked freelance, I run away from people in this manner, but the man in here is also like them.' 'Is that so? Well, okay then, it is. We will put it here. However, finally, what emerges as a product is meeting the expectations? It is ridiculous to adapt to people; it is ridiculous to stay out too. I have been able to balance that lately".

The situation that the participant frequently talked about was the interference from others to his profession and way of doing work. The satisfaction diminishes when he acts according to the requests of the other parties who do not have expertise on the task but who insisting on interfering with the process. This experience is so natural for anyone who has expertise in a particular field, and who does not like the manipulations coming from others; however, managing these interpersonal problems is among the soft-skills needed in work settings, this comes up as a problem for employees with bipolar disorder because their agreeableness may not allow a compromise.

P7's experience of conflict is as follows:

> "Because when he becomes authoritarian, we conflict. Because I am an authoritarian individual too. I have leadership characteristics. He also has leadership characteristics, and we get into conflict. He says it will be what I

say, I say it will be what I say; so we could not agree, we could not agree at all".

In this example, we see an example of a conflict that arises with the lack of compromising attitude. However, finding a middle way in work-life and establishing a win-win relationship is a vital competence. Of course, it is possible to criticize and change the non-constructive and authoritarian attitudes of the other individual; however, since the participant can control her feelings and behaviors, it may be a sign of success in terms of the desired attitude and even interpersonal relations.

3.4.2. Organizational / Work-related Difficulties

We also see that the participants face difficulties arising from organizational processes and cultures.

3.4.2.1. Work Hours and Workload

P4 shared the difficulty of time in the following way:

"But I know the hospital culture, they told me 'there will be two shifts at most'. I guessed '3-4 are for sure'. Because I know it was always going to be more than what they propose in the hospitals. Colleagues quitting the job, or having a pregnancy, and so forth... Without the new recruitments, I felt that the workload would be transferred to us. Indeed, it happened. Working life did not mislead me". (P4)

We observe that the participant experienced a burden about successive shifts. Damage on the person may be inevitable when working hard during the day in addition to a shift.

P6 also has the following ideas about working and off-days:

"For example, I can never work with official 15 days off. So maybe I chose to teach. You know, plenty of breaks. I am unhappy when I work at the

weekends. I am unhappy when I work until 7.00-8.00 in the evenings. I am unhappy when I am obliged to work. I also volunteer until 10.00 pm. But if I work with someone's force, I am unhappy" (P6).

We observe that the participant establishes a relationship between career choice and holidays. The participant adds the possibility of being unhappy when she is forced to work at the weekends or during holiday time. She also emphasizes that working in a job where autonomy to make her work plan and the program is a critical criterion for her. The inflexibility may create a burden for the individual.

The flexible working arrangement is discussed frequently in today's business world and comes up with various corporate practices. The flexibility related to time and space, 'working four days a week and having three days of vacation' or 'working one day at home if working five days a week' are some of the most common practices. The data obtained from the interviews showed that the participants are complaining about the lack of flexible working. P4 mentions that "I am saying that working days should be less", represents the desire for flexible work. We see that the participant wants to have a job but has difficulty in conditions. We see that he does not want to work long hours or six days a week.

3.4.2.2. Physical Conditions

The physical conditions of the workplace can also have compelling effects on people. Open office environments can be beneficial for some individuals, but it turns into torture for others. Considering what physical conditions affect the participants, P9 mentions: "I felt exhausted because people's voices irritated my mind. I could not stand it". The open office environment is too noisy that cannot be tolerated which has a negative effect on her.

P8's difficulty with physical conditions was as follows:

"It was scorching outside in the summer season. When you go out for a break to smoke or drink tea, it turns to torture. We were staying in a tiny container after all. Of course, some others were living more comfortably, I was an engineer, but [*the company*] found me a place where even the toilet

water was boiling. As I said it was distressing me. We were working from 7.00 a.m. in the morning to 7.00 p.m. in the evening. The food in the construction site was incredibly bad; I do not know what kind of fat they were using" (P8).

The participant's experience of working abroad seems destructive for both physical and psychological health. The weather was scorching, the living conditions were non-humane with small rooms for overnight stays, the working hours were long, and the food was terrible. These conditions would not only have a negative effect on people diagnosed with bipolar disorder but would impact anyone. Employers should create humane working conditions for all so that the conditions would turn to be advantageous for those who have chronic health problems.

3.4.2.3. Difficulties in Adapting to Culture of the Organization and Commitment to the Organization

Every organization has its own culture. For example, while some organizations have a flexible working system and a philosophy that prioritizes humanitarian values, others may be more competitive and do not pay much attention to decency. The organizational culture determines how these values are put forward.

The problem which was experienced by P4, is as follows:

"My father is like… Fathers talk a little bit more; 'do not be demanding, obey, etc… [*talking about his father's advice*]. I said 'there is no promotion, no decline here'. I said, 'until I retire, I cannot get any higher position, so I am not happy with that.' Because it is ridiculous… 'if it is health sector [*he talks about the healthcare industry his father recommended*] I do not want health or anything,' I said. So I thought it was not good for me" (P4).

It should be emphasized that he does not want to work in an institution where he has not seen any progress in his career, and the institution could not provide any development on his personal and professional career.

P6 describes the difficulty as follows: “I think it was the worst year of my professional life. In other words, I realized that it was an organization that did not fit my philosophy and my vision at all”. The participant stated that she did not feel any belonging to the institution and the reason was the culture of the institution. It would also be added that she had the worst working year in her life. She elaborates on her experience as follows:

> “You know, I am closing [*myself*], I have a shutdown button. That is when I shut myself down where I did not feel belonging. I did this at X College. I closed myself for a year. I have an on/off switch against people. Right now [*in the new school (Z)*] that button is open. However, when I have such a negative attitude, I turn it against people and especially certain people. It is like a switch. I developed small techniques within myself”. (P6)

In organizations where she does not feel belonging, the participant is withdrawn, and she closes herself against the people around her. *Z College which was* emphasized that she liked the college's philosophy very much during the interview and stated that she did not have such difficulties there.

P4 reports that he left a company he was working in due to lack of adaptation and orientation support:

> “I left voluntarily. They never dismissed me. In fact, I thought that the 2-month period has passed, they should call me to inform that they are pleased, to say ‘let us continue with you’. I was always in this view. But they did not give feedback to me. If they were satisfied, the initial labor agreement could have continued automatically after two months. I did not even know that. Look, I am 30. I do not know my rights. Instead, I finally said, this will not happen, and I left” (P4).

The organization should provide employees a guide to support the process of adaptation and orientation. The participant experienced a lack of such support and decided to quit voluntarily. Then how can we evaluate the decision to leave instead of taking a step further to learn the options to stay?

The main competencies are to guide the people working under the managers, to take the role of instructors where they are forced and to contribute to the development of the employees. It is also discussed whether these mentors should be managers or not.

We can evaluate the following discourse of P4:

> "My manager was very shallow. Shallow… Not in the sense of knowledge. I already told him; 'Please sit down one day, work here one day, understand the difficulties here.' I think that is what management is about. Know the jobs here, know our difficulties and try to help" (P4).

We see that P4 is working with a manager who is unhelpful in manners and gets distant toward the work too. Underpinning the need for the helpful attitude, a manager who is ready to listen to the subordinates, what P4 needs is mentoring, and a manager who is leading and motivating people.

3.5. MEANING of WORK

Earlier, we mentioned that working has a therapeutic effect. Working is one of the psycho-social support dimensions for people with psychological health problems. Working in a job that is meaningful for them has a positive effect on the prevention of attacks. What does the working mean for the participants and how do they position it according to their past and present experiences? When we asked about their perspectives on working in general, the participants had more positive views. Table 3.6. indicates the sub-codes related to the meaning of work.

Table 3. 6. The Relationship between Working and Meaning Positive Feelings

Positive Feelings
The flow and forgetting 'everything' during working
Relationship between work and happiness (accomplishing, work anxiety and challenging works)
The desire for work after abstaining from work-life (monotonized daily activities, feeling useless, unwillingness and meaninglessness)
Development of social abilities (communication, sense of confidence)

3.5.1. The Flow and Forgetting 'Everything' during Working

We frequently see that the feeling of flow as engaging in tasks prevents people from repetitive negative thinking. For example, P2, with the uncontrollable tendency of social isolation during the depressive episodes mentioned: "… Only coming to the work is not included in this (depressive episode); because at least when I come to work I know that I will distract myself". The distractive effect of work on rumination and the flow as dealing with the tasks at work setting lead the participant to develop positive attributes about the meaning of work. Not only in the depressive period but also in general "… I like working. I like engaging in tasks" (P2).

On the other hand, P3 makes a comparison between being at home and being at work: "*[Work]* makes me feel good. I feel bored alone at home". He emphasizes that the current team he is working with is perfect for him and he feels excellent as staying focused on a task.

P6, who is working with children as a teacher, approaches:

> "… children make me forget everything. Is that good? It is good in that sense. In other words, I have no more endurance during the depressive periods, but a tiny favor and naïve manner from the children's side are helping me a lot. It is like storing energy".

"A tiny favor from the students" positively affects her mood, helps to forget negative feelings, and maximizes her endurance. Similarly, P7 states that: "I want to work like crazy even though I am in the depressive period. I like working very much". P7's positive attitude towards working, in general, is connected to the experience of the flow again:

> "When you are at home, or when you are alone in a quiet environment, the brain does not stop, constant thinking... While walking on the road, sitting, getting up, this brain never stops thinking. Especially during the depressive period, you cannot suppress or let the brain be quiet; but when you work,

you are absolutely distracted because you dedicate yourself to work, and that is why I love working". (P7)

Again, we see a comparison between being at home/being alone and working. The positive effect of flow by focusing on work prevents repetitive negative feelings and rumination.

Similarly, P8 puts the following statement: "If we move out work from our lives right now, there is nothing else to worth to live. Just void! In this emptiness, an individual thinks more than usual". The work is a dynamic that should be in people's life since the contrary means the state of doing nothing, which activates the unstopping thinking process. Moreover, P8 says: "When you are in that gap, we may tend to engage in 'bad things'; working is functional even for that reason". By 'bad things', P8 refers to thought and behavior patterns that can trigger depressive or manic attacks or thoughts that always tamper with his mood and emotion he has to struggle. We understand that working is critical for people with bipolar disorder, in terms of getting the flow and stopping rumination. Working may prevent thoughts that can be automatically triggered in the mind when the individual is free.

One of the participants emphasizing the home environment as triggering negative emotions is P9: "In other words, people are always grieving/feeling sad at home. The home environment is not good". We see that the participant who encodes the work environment as favorable accuses her family environment as triggering negative emotions, i.e., sadness. The participant also adds: "The thoughts in my brain bothers me".

Similarly, P10 reports: "I was always in the avoidance. I always escape from people, myself. I embrace business and work-life because I see it as an escape; when I get into work, I forget everything. I suddenly recognize that it is 7.00 in the evening, time to leave". We see that the feeling that the participant calls "escape" causes her to cling to the work.

The flow at work is undergone directly or indirectly. We can talk about the tendency to work and flow with the influence of themes such as 'non-stop' thoughts

in the brain, negative feelings are brought by the depressive period and daily sadness/distress.

3.5.2. The Relationship Between Work and Happiness

To understand the relationship between work and happiness, we can look at P7's expression: “I have never made *[mistakes]*; but you always work with that concern. That is why you are so happy when you complete the day without any problem”. Even though she works in anxiety during the day, she emphasizes that finishing the work at the end of the day without errors has a direct positive effect on happiness.

Secondly, we may highlight the effect of the feeling of success on happiness through P7's citation: “I become productive, produce things, and accomplish something. Happiness cumulates with every tiny thing I accomplish. I say I succeeded, I can do it”. Productivity and feeling successful trigger happiness. P10 approaches this issue as follows: “I do not like easy jobs”. The participant expresses that the feeling of happiness which comes out when dealing with challenging tasks is right for her. The challenges of work that lead to the use of different competencies give a chance for skill variety. A higher workload and limited time -depending on the content of the work- may activate personal development. Working is not only the tool to fill “the void” but also a channel to get a sense of accomplishment as it applies to almost all employees.

3.5.3. The Desire for Work after Abstaining from Work-life

In the theme of the desire for the work caused by staying away from work-life. We see that when they are not working, boredom due to routine/social activities, feeling of uselessness, reluctance, and meaninglessness are emphasized themes.. For example; P9 gives the following information about routine social/daily activities: “To some extent, touring; it does not give you pleasure, after all, the same thing you do constantly; sit in the cafe, have a drink, chat, get up, go home. So… Now it makes you boring after a while”. When she is not working, we see that she has a desire to work because her activities turn into a routine.

When we look at the feeling of uselessness, P10 adds: “I feel useless, unqualified at home”. Here, there is a need for a contribution to something, and a desire to work is related to this need. When asked what happened as a result of sitting at home, P10 reports that “unwillingness to do something” and “the inability to enjoy” what she does because she does not work. Could work be an essential meaningful area in the participant's life? At this point, it is essential to include P9's sentences: “At least I have a purpose. How far will I live without any aim?” We see that P9, who states that working adds a purpose and a meaning to her life, has the desire to work thanks to this reason.

3.5.4. Development of Social Competencies and Personal Awareness

We can also see that working is positively positioned because it has the effect of developing social competencies. After talking about the destructive emotions he experienced after the episode, P5 mentioned about some of the skills and feelings that he developed as a result of starting to work: “My communication became open, my self-confidence began to increase a little bit more”. With starting to work, his communication skills and his self-confidence positively developed. In this context, the work-life/work environment can be considered as an excellent opportunity to develop social competencies.

3.6. SOCIETY, FAMILY AND HUMAN RESOURCES MANAGEMENT PROFESSIONALS’ PERSPECTIVES ON BIPOLAR DISORDER

In the current research we asked about the perspectives of third parties and institutions, the perception of society, human resources management professionals, and family. In order to elaborate and comprehensively grasp these views, the emphasis on the discourse that provided clues about the attitude of society, human resources management professionals or family could be grouped under various attitude components. In other words, we have caught the indicators of discourse on affection, cognition, and behavior. In some discourse, only one component became

prominent, while others took part in all three components. Table 3.7. shows the attitudes of these third parties and institutions towards diagnosis in terms of affection, cognition and behavior indicators.

Table 3. 7. According to Attitude Components

	Affection	**Cognition**	**Behavior**
Society	Disdain and pity	Level of consciousness/ awareness *"The conscious person approaches differently."* *"They discern of the diagnosis when they personally expose to it."*	Supportive Suggestive [*telkin*] Indifference Association of the behavior with the diagnosis "*I say the way I am. They say: 'No, you are bipolar.'"*
Human Resources Management Professionals	Apprehension and suspicion *"Does he/she cause a problem in the future?"*	Level of consciousness/awareness *"If he/she knew what it is, he/she would hire."* *"He/she thinks that I interrupt the work."*	They have a procedure to follow
	"If I share it, he/she can start with '-1' instead of recognizing. His/her perspective changes."		
Family	Concealment tendency ("Do not tell anyone!") Rejection		

3.6.1. The Society's Perspective

When evaluating the perspective of society, the participants expressed their opinions about the harmful components of the attitude. We acquired the following sub-codes; in the affectional dimension; disdain and pity, in the dimension of cognition; the level of consciousness, wannabe and being aware when it is experienced, in the behavioral dimension; supportive, suggestion, indifference, and association of behaviors with the diagnosis. Only the supportive attitude is located in a more neutral position; it is worth mentioning that all other attitudes are negative.

First of all, if we talk about the affectional dimension, we can include the discourses on the theme of disdain and pity. For example, P7 says: "They show some reactions and talk pitifully". The participant said that the people whom she

met, pity her when she contacted them. May experiencing pity from others cause what kind of feelings, thoughts, and behaviors? Does a person feel down in a vertical position instead of horizontally on a hierarchical social construct? Can it be said that pity has a hierarchical feature as emotion?

P10 expresses another discourse containing a hierarchical context like pity and its' affectional definition is disdain: "Mental illness comes to their mind immediately; as 'mad and maniac'. There are disdain and marginalization". P10 talking about the various stereotypes mentions marginalization. In addition to the hierarchical structure as in pity, we also see the effect of the marginalization that excludes the person from the 'society'.

If we examine the dimension of cognition; firstly, discourses related to the level of consciousness will be mentioned. When the participants talk about the level of consciousness, they make a categorical distinction, consciously or unconsciously, and emphasize that people's attitudes may change in this direction. For example, P5 makes the following statement about the level of consciousness of the society: "They do not have awareness and learnedness [*bilginlik*]". The participant has a belief that society has no knowledge of the diagnosis; he uses the word "learnedness" to denote that they do not have knowledge. Moreover, he adds the following sentence: "They have a susceptibility of the diagnosis when they experience to it" (P5). It is emphasized that consciousness and awareness develop if people experience the disorder themselves or someone close to them. We see that P3 has a very similar experience:

> "My friend's mother also has bipolar disorder: she cannot sleep at night, annoys everyone at night, annoys everyone at home during the day, does not stop at all and has an episode from time to time. I mean, he knows, he approaches me differently. The way he looks at me is different". (P3)

We see that personal experience or witnessing people with bipolar disorder in their surroundings have a vital role in these two discourses.

In the behavioral dimension, we see the indicators of behavior emphasized by the participants while conveying the perspective of society. After sharing the

diagnosis of P3 with his environment, he says he has a “supportive attitude”: “they are trying to help me and tolerate my problems; because I have a psychological disorder”. Since a person is diagnosed with a psychiatric diagnosis, the possibility of additional supportive treatment can also cause damage to one’s psychological world. A cynical approach to diagnosis can have a devastating effect as well as an excessive positive approach.

Another sub-theme we encountered in this dimension was shaped by the following discourse of P7:

> “I mean, I am annoyed by their talking style. That is why I am running away from people. ‘Dear, you are too young, why did you do that? Look; your mother died, look what happened to you, how many times have you been hospitalized? Why are you doing this to yourself? Heal yourself, feel better, stand up, do this, do that or something…You cannot let them understand that I cannot do it!” (P7)

We see that the participant, who stated that she felt uncomfortable about people's suggestions, developed an avoidance behavior from people. The participant explains that they have an attitude about perceiving herself as a reason for her episodes. Against this “accusation”, we understand from the last two sentences that the person lives a sense of ‘stuck’ with the expression of not being able to tell the situation even if she wants.

P3's discourse referring to indifference was as follows: “… I say to every friend I know: my illness is bipolar. ‘Oh yeah?’ they say, passing. But they do not elaborate by asking; ‘How is it happening, what is happening, what expressions are there, what effects are there?’”. We see that P3 also has a complaint that people are indifferent. There is a need for understanding. Instead of understanding the situation, people prefer to remain indifferent, which bothers the participant.

P4 reports that some of his daily or natural behaviors are related to his diagnosis and he says: “Everybody says ‘You are bipolar’. You are saying I am P4. No, you are bipolar”. He states that the other side establishes a relationship between the self/identity and his diagnosis. He feels uncomfortable about it. Basing person's

personality traits and behaviors on diagnosis create self-questioning and internal conflicts.

3.6.2. The Perspective of Human Resources Management Professionals

When we look at the participant views of human resources professionals; in the affectional dimension, we see that "apprehension and suspicion" are mentioned.

If the participant would share her diagnosis at work or in the job interview, she predicts that:

> "I think it is [*the diagnosis*] apprehension for them. I mean, 'Is this going to bother me at work?' 'I am hiring, but what if the episode comes out at work?' Because they do not know. 'What would I do if he/she does something?' 'Will it harm us?' I have also met those people who say this in my daily life. I think this can be a bit of a negative evaluation in terms of them. So, it definitely changes their perspective" (P6).

The participant talking about the apprehension state, has associated with doing harm/damage and the possibility of further distress. According to the participant, human resources management professionals have a feeling of "concern" and "suspicion" about the individual with bipolar disorder. Particular emphasis on the potential for harm shows that other people have an idea that individuals with the bipolar diagnosis can harm the environment somehow.

When we look at the dimension of cognition; P7 makes the following identification about consciousness:

> "If I can explain to the HRM professionals what bipolar is, he/she can hire me if he/she has the capacity to understand it. If not, I think he/she would contemplate it because I am a financier. I do not think they would hire a financier without knowing what bipolar is" (P7).

Here we see a negative attitude towards the diagnosis due to unconsciousness or lack of comprehensive knowledge about bipolar disorder.

According to the participant, if the HRM professionals are uninformed about this disorder, he/she contemplates about the person who has bipolar diagnosis during hiring since it is a psychological disorder. In addition, the participant emphasizes that it is provocative that her profession (financier) coexists with the diagnosis.

P8 also makes the following statement for human resources management professionals related to diagnosis: "I do not think they know much". In addition to P8, P2 also articulates the following sentence about the level of consciousness:

> "It was XYX who hired me. At least she acknowledges the bipolar disorder, I have such an observation. At the same time, my friend who is working in the office environment and I work together, is very sensitive. She notices and without judging says: 'You do not feel well today'. I might have been reflecting my emotions unconsciously, then I bounce back; this is good for me too". (P2)

The human resources management professionals in the organization where he works have knowledge about bipolar disorder, so that he feels "easy" with them and is not disturbed by their attitudes.

When we look at the dimension of behavior, P10 says:

> "… but unfortunately, they have a human resource management profile that they should follow. I cannot blame them too much either. Knowing their responsibility towards the employer (the boss)… For example; you are a human resource management professional, I am an employer (the boss), this friend of mine is a bipolar patient and needs work. Not a disabled person, a very healthy person, only he has bipolar disorder. He talks to you, you hire him, and you report to me: 'I hired such a person, this person'. And the boss – we are talking about bosses in Turkish society – says; 'My dear, how merciful you are…! Are you going to sink me?' I imitate with vulgar expression; because they are" (P10).

At this point, we face a comment that human resources management employees are not able to make decisions on their own, that they are under the

influence of the corporate culture, the manager or the boss they are affiliated with and therefore they should not be “blamed”. In other words, we see that there are other factors beyond the decision of the person who is based on the behavior of rejecting for a job.

We will consider another discourse in terms of affection, cognition, and behavior. When P6 shares the diagnosis, she predicts that she might encounter this: “If I share it, he/she can start with -1 instead of recognizing”. At this point, it is emphasized that HR professionals have a negative attitude called “-1”. Instead of trying to get to know the employee from a neutral point, they predict that they will start with an adverse judgment.

3.6.3. Perspectives of the Families

When evaluating the attitude of the family, we observed that all discourses serve both affection, cognition and behavior dimension.

First of all, we can read from the following statement of P1 that the family has a tendency to hide: “… but my parents and also my friends told me not to tell anyone”. We can say that the family has such an attitude due to lack of consciousness of other people, negative coding and affectional reactions individuals with bipolar disorder may encounter.

P6 also shared another comment: “… but I could not even get my mother to accept the idea of going to the psychiatrist for a while. Mothers, Turkish mothers experience a little traumatic to events. ‘You are fine, you are actually depressed’. They associated everything with being unhappy due to breaking up with my boyfriend”. The participant states that even at the point of going to the psychiatrist, even the acceptance of the diagnosis, her mother did not accept going to the psychiatrist and attributed the depressive episode to her separation from her boyfriend. The rejection of the family is a critical problem.

CHAPTER 4

DISCUSSION

First of all, this thesis aimed to investigate the work-life experiences of employees with bipolar disorder as a pioneering study in Turkey. This study brings ideas on interconnections between organizational, social and clinical psychology perspectives. The major themes emerged as “a relationship between mania/hypomania episode and work-life”, ”a relationship between depressive episode and work-life”’, “views about sharing/disclosing the diagnosis”, “difficulties at work-life”, “work and meaning”, and “perspectives of the society, human resources management professionals and the family”.

When we focus on the relationship between mania and work-life experiences, we can maintain the discussion around working style (productivity/overwork) and controlling the mood. Increasing energy could seem to be a symptom of a manic episode. We frequently heard the discourse about the elevation of productivity. The mania episode leads the individuals to transfer their energy. Apart from the productivity, P10’s this sentence can open different topics: “During the mania period, I wake up pretty good, get up, get ready, I go, I work, I have good relations with people, and I go home in the evening in a peaceful way since I did my job well today. I feel more efficient in that period”. We can see that she mentioned elements of well-being in the workplace such as; sleep regulation, personal care, good relations with co-workers and job satisfaction.

Moreover, as P6 said “… I could do many things, I could help people, I could join associations, maybe that is why I started *XXX* Association and volunteer work”. Can we establish the relationship between higher compassion as mania symptom and volunteer works?

How do we evaluate the code of showing tolerance/not to feel distressed under the title of controlling the mood? Could it an indicator of over and intense happiness in the mania phase? Some researches show that individuals with bipolar disorder apply mostly in the depressive period for taking support. In mania period,

the family or surrounded others could be a pioneer for taking support instead of taking individual support.

If we focus on the relationship between depressive period and work-life, difficulties of communication are the dominant theme. We can see that most of the participants avoid communication. Furthermore, some of them prefer communicating via written means such as; short message service, e-mail or some smartphone applications, instead of oral communication. How does oral communication evolve the written one? They cannot stand hearing a voice from someone. How does this situation affect working style? If they have an important meeting, how do they deal with this difficulty?

On the other hand, how do their co-workers perceive these radical changes in one's behavior? If they do not know individuals' diagnosis, may they seem inconsistent? Could perceiving inconsistent reduce the confidence to them from their managers or co-workers? It should not be forgotten that instability could be scary.

Another point is that some of them emphasized that they hide their intense emotions in that episode. There was a conflict between their professional behaviors and authentic behaviors. From a clinical perspective, despite the intense depressive emotions, how does extra effort for hiding affect one's psychological health and mood? Sharing the diagnosis with only managers or other business contacts can be beneficial both for a person's psychological health and professional career. If a person does not choose to disclose the diagnosis, he/she should apply to support channels (e.g. his/her psychiatrist) for regulating their medicines as soon as they feel signs or symptoms.

What are the factors that affect the decision of people to share or hide the diagnosis? While the participants share their diagnoses, we see that they do as a need for understanding, not to be judged by their co-workers due to their abnormal behaviors which likely occur during the manic or depressive phase and proactive reaction. Communication as an essential component of work-life was emphasized in these three discourses. We can say that deciding disclosure is a step toward to

protect and not to destroy existing relationships because there were lots of references for protecting their relationships. If healthy communication should be maintained so that works (things) can go on. A healthy and stable communication brings a sense of trust. The sense of trust sustains the dynamics of many relationships in both organizational and social life.

P6's disclosure experience was happening differently. While she and her colleagues were going out for socializing, one of her friends said that she was a bisexual. Then P6 shared her diagnosis. Bisexuality and bipolarity are two marginalized identities. However, disclosure of one of the marginalized identities (bisexuality) empowers others to uncover their concealable identities as well. We are witnessing the experience of sharing their marginalized identities starting from a common theme such as being discriminated. It is possible to say that collective experience has a unifying power. The presence of someone with different identity but with the same concern (to be discriminated) has a soothing effect on P6.

What kind of reactions have people faced after sharing? P1, P3, and P6 have undergone more supportive attitudes when they have lived any difficulties at their workplaces. On the other hand, P3 witnessed that his manager shared the participant's diagnosis without his consent. Furthermore, P10 who was sharing her diagnosis during the job interview was not accepted to the job, although she passed all processes. This clear public stigma experience taught her to hide her diagnosis. Not knowing of reactions from others is an essential reason for hiding the diagnosis.

Another point is that, while they were sharing the diagnosis, they felt compelled to make a detailed explanation of the diagnosis like "it has a treatment", "it occurs because of the lack of lithium" and "we are not mad". They urge to elaborate on the diagnosis due to the lack of awareness in society. This might be a tactic protect themselves from stigma. Can we also say that this is exhausting to show extra effort to protect oneself from the stigma? Isn't it a worrying thing to know that such a threat always exists in common social areas? At this point, employees in organizations should be attention to their discourses. When they are talking about something and joking, they should not use psychological disorders to define the situation or despise someone because the discourses are dominant

carriers of stigma. Knowing that such a perception exists does not only make it difficult for the person to accept the diagnosis, but this perception can have devastating effects on the psychological health of the person.

When we analyze the chapter of difficulties in work-life, personal/interpersonal difficulties and organizational difficulties affect the participants. Personal/interpersonal difficulties are formed by mostly the diagnosis. For example, P9's fear of dismissal occurred after receiving reports due to the diagnosis. If she takes a day-off report due to her physical illness, would she feel the fear of dismissal? The side effects of the medicines had some problematic effects on the participants. While P8 having difficulty in remembering received orders from his manager or subordinate, felt sorry how he could not think of it. In this way, he started to compare himself to others and reduce the tolerance to vulnerability. For these reasons, he stopped using medications. We can easily say that it is related to the participant's personality. However, interpreting this situation as the P8's personality may cause us to miss some critical parameters of organizational culture. Especially these days, competitive organizational culture, not accepting mistakes or/and expecting perfect performance from employees could come to be very problematic in terms of employees' psychological well-being. This situation caused P8's stopping to take medicines, but it also had destructive effects on employees without bipolar disorder or other psychological disorders. This is an essential discussion for organizations to bring their culture to more humanitarian conditions. For example; managers can tell employees under them that making mistakes is commonplace. In this way, employees can feel more comfortable, authentic and transparent to each other.

Moreover, starting to use medicines can cause changes in participants' cognitive abilities because they compare themselves (their abilities) to their conditions before taking medication. P9 sometimes cannot understand something which is told by her co-workers or managers. Therefore, she feels that they can understand her diagnosis. Side effects of the medicines can make some concerns about the diagnosis.

Some of the participants said that they show impulsive behaviors in some cases. P3 emphasized that when he was exposed to be ridiculed by his students or coworkers (teachers), he could feel angry and fight with them. However he especially underlined that if there were not any stimuli, he would not apply to impulsive behaviors. It is useful to give the following information; he experiences these events especially when there is a wrong treatment and when he is not diagnosed yet. Abnormal behaviors of the manic/depressive episodes can be ridiculed. We can easily say that this is discriminatory regardless of the manic/depressive episodes. Is it possible to say that this is some mobbing behavior? The person who was the victim of mobbing (P3) was angry as a result of this behavior. When we look at the damage or consequences of mobbing, we see that there is anger. This cause-and-effect relationship can show us that P3 is a victim of mobbing. (http://www.psikiyatri.org.tr/halka-yonelik/15/yildirma-mobbing) It is also questionable how people find the power themselves to easily ridicule these abnormal behaviors? Various intervention methods should be developed against this discriminatory behavior that we frequently encounter in all areas of social life. While people experience many difficulties, they are also exposed to dealing with this behavior. One may feel ashamed to be excluded from society, be reluctant to establish social relationships. Thus instead of undergoing therapeutic/healing power of relations, he/she can experience its destructive ways.

P3 also gets impulsive if exposed to inequitable conduct. He got angry with his manager about changing his schedule for revising the other teacher's schedule as the teacher wished. We witness a glaring example of injustice application. If the employee experiences injustice/unfair applications, he/she can be unhappy. Feeling unhappy reduces motivation, which is directly reflected in the employee's performance. People who are around unhappy and low-motivated employees are also affected, and the unhappiness spreads to the other employees. The unhappy employee reflects this unhappiness to his/her private life. Thus, the life satisfaction of the employee decreases. His loyalty to his work and his workplace falls. All these practices have e unfavorable and adverse effects on individuals who are not diagnosed with bipolar disorder. We do not say that people diagnosed with bipolar disorder are more vulnerable position to these applications.

The most crucial point to be emphasized here: if humanitarian working conditions are provided for everyone, the workplace problems related to bipolar disorder of people are reduced.

To give more example; P4 experiencing shift works three times a week, felt boredom and questioned his work. As a result, his loyalty to his job can diminish and begin to deprive of the positive impact of the work. In addition to this, we should not miss the importance of sleep hygiene in people with bipolar disorder. A work environment with shift work can trigger the episodes. Frequent shifts may have devastating effects not only for people diagnosed with bipolar disorder but also for people without any psychopathology. In this context, if it is known that there is an employee with bipolar disorder, he/she should not be worked overtime. If the person has been working overtime, it may be advisable to use the right not to work for the next day. However as mentioned above, if humanitarian working conditions should be widespread on the organizational cultures, employee health may be protected.

P8 stated that he had traveled to a warmer region due to his job, but he had difficulties. The first thing was that the weather was too hot, and he emphasized that it had turned into torture. He had a tiny place that he had to share with another colleague to stay there. Very many working hours, combined with the challenges of physical conditions, may have made the P8 even more difficult. He lastly added that the taste of the food did not fit his taste. All of these factors can cause experiencing difficulties. They should be evaluated under the humanitarian working conditions.

In the title of work and meaning, we see the positive effects of the work. Participants mainly referred to therapeutic effects on the depressive episode. The negative feelings experienced during the depressive period were reduced by moving into the flow. However, at this point: can hold to work in every negative mood be evaluated in the context of repression defense mechanism? It is worth mentioning that multidisciplinary studies are needed in the field of clinical and organizational psychology. On this intersection, work could be a tool for using repression defense

mechanisms since lots of participants emphasized the forgetting effect of negative feelings.

We faced more negative opinions under the title of from the perspectives of society, human resources management professionals, and family about the diagnosis. We can say that pity and disdain are the most common emotional reactions in Turkish society. In general, identities marginalized by society face either pity or disdain. How does seeing pity reaction from the other person feel oneself? Pity is usually given as a supportive reaction ("I understand you"/"I am with you") since the person is in the excluded position, but it makes the excluded person negatively feel. The person positions himself/herself lower side in the relationship with feeling hierarchical structuring. Disdain is intended to be a direct offense with any respect for the other party. There is hierarchical superiority in both attitudes (pity and disdain).

Another point is that the participants felt some stereotypes such as dual personalities *[çift kişilikli]*, showing intense and over-emotional reactions and wannabe from the perspectives of the society on the diagnosis. How have they had these stereotypes? I feel that media, social life or/and work-life shapes this perception. For example, when someone with bipolar disorder has a meeting, and one of his/her friends can express an opinion about bipolarity, such as three stereotypes above. Here, firstly, we can say that the discourses of the person giving this opinion on assumptions and misinformation is an external stigma. The person also behaves with the assumption that no one has been diagnosed with bipolar disorder in the meeting. Secondary; Assuming that there is a person diagnosed with bipolar disorder in the environment, the person's relationship with the diagnosis in his / her inner world may change, and the internal stigmatization process may begin. The person with bipolar disorder who experiences that people have misinformation about bipolarity around him/her, may feel shame, anger, and blame and thus it creates another problem in person's life.

When we bring supportive attitudes up for discussion, we have difficulty to position on negative or positive sides. The supportive attitude of the manager or colleagues may be red positively in situations where the person has difficulty.

However, an over / extra supportive attitude (always observing, frequently asking for needing help, trying to make him / her happy) should be described as a negative behavior. The point to be considered here is that; people should be supported in matters/issues that they want help.

4.1. Implications of the Research

When the findings of the research are examined, it is seen that manic and depressive periods have a severe effect on the situation of people in professional life. Firstly, the changes observed in their attitudes may become questionable by their colleagues. Assuming that the diagnosis is unknown, the person may be coded as "unstable", “doubtful” or “inconsistent”. On the other hand, work may have a therapeutic effect for people diagnosed with bipolar disorder. Therefore, individuals with bipolar disorder should manage the situation (the diagnosis) rigorously in order to draw advantages from work.

It is worth noting that many of the difficulties in individuals other than their manic and depressive episodes are independent of the diagnosis. Future studies that focus on these points can be useful in order to prevent stigma.

When the participants have talked about disclosure, it is evident that they are worried about the stigmatizing ideas created by society. There should be educational and awareness-raising activities for the society. People should be encouraged to gain their profession rather than being imprisoned at home because of these stigmatized attitudes.

This research has identified difficulties experienced by individuals with bipolar disorder in social and work-life specifically. At this point, both organizations and individuals with bipolar disorder should take training in order to provide psychologically healthy work environments and make professional life sustainable. Stigma towards mentally ill people also has an ongoing social problem in Turkish society therefore NGOs and policymakers also have a lot of responsibilities to prevent it. Stigmatizing attitudes are also presented in work-life being a part of social life. In order to prevent these attitudes, educational and informative works of non-governmental organizations and legal arrangements of policymakers will be useful.

What should organizations make to create healthy work settings? First of all, they should provide training for all employees about psychological disorders and their effects or no effects on work-life. Organizations in their training should emphasize that these people do not only consist of the diagnosis, and they have experienced psychological disorders in a certain period of their lives, or they are likely to experience similar period in the future. It may also be stated that the speeches stigmatizing mental illnesses should be avoided. Occupational physicians shall be informed about psychological disorders since our research shows that they do not have enough information relating to them. Managers can be given training on how their relations with the employees working under them should be because holding environment which is a term of Winnicott is essential to establish healthy relationships. Flexible working hours may be supported as an employee with bipolar disorder or any diagnosis could want to work at home some days. An open office environment could have a destructive effect in some periods for individuals with bipolarity since they cannot tolerate noisy environments in depressive periods especially. When a person requests a relaxing and quiet office environment, employers or managers should be understanding in specific terms.

The participants expressed confusion and concern about whether the diagnosis should be disclosed or not in work settings. They may be open to their managers in certain circumstances because the diagnosis can affect their work style, relationship with co-workers or other elements of the organization. If the diagnosis is explained correctly, managers and other workers may understand the situation. On the other hand, if it does not affect the working style or other elements of the organization, there is no need to share the diagnosis. Apart from the disclosure matters, employees with bipolar disorder should be careful about the point of regular drug use. They should be in close contact with their clinicians and should not stop taking the medication without asking psychiatrists. In cases where the drug is not solved or there are other personal problems, psychotherapy should be gotten. They also follow the psychoeducation programs in their region because psychoeducation is an essential dimension of psychosocial support in bipolar disorder. These supports help to regulate daily life and professional life. They should avoid taking too much responsibility in their organizations as extra

responsibility can trigger stress. This does not mean that only the given work is performed. By all means, small responsibilities should be taken because taking such responsibilities is very important for career development. Career development is also a factor that can increase one's job satisfaction. But because too many responsibilities bring too much work, it can have a disturbing effect on the balance of daily and professional life. Rest breaks at work should be used definitely. Taking a break is a very substantial activity to focus on the work efficiently. Working in rest breaks at work may decrease the efficiency of the work done and is also risky in terms of psychological health. It may also be good to go out and do breathing exercises instead of staying in the office during rest breaks at work. Shift works, night shifts or jobs which demand you to be awake at night should not be the right choice since sleep regulation is essential to maintain remission periods. It is also helpful to ask advice with support networks if they have difficulties.

4.2.Limitations of the Research

Firstly, before interviews was started in this study, the researcher interned in the mood unit of Çapa Medical Faculty in order to comprehensively grasp the diagnosis and find a participant for the research. Most of the people denied being a participant in the study. It caused an extension of the research.

Ten participants were sufficient according to the requirements of an IPA technique, but if more participants were reached, much more comprehensive results could be achieved. This is the first time this study has been done in Turkey so more comprehensive studies may be conducted.

Some interviews were done in public places such as cafes. It could make that participants may not be able to express themselves sufficiently.

4.3. Future Studies

This study was held first in Turkey because of the relationship between psychopathological diagnosis and work-life. However, since each pathology has different symptoms, results, and experience, this study was conducted with individuals diagnosed with bipolar disorder. Studies describing the work-life

experiences of groups with different psychiatric diagnoses and personality disorders can be done. Even more specific studies of bipolar disorder may be researched. For example; relationship between depressive episodes and work-life, disclosure in the working environment, management of the return to work process after sick leave or hospitalization due to depressive/manic attacks are some of the topics need to be studied in future.

The last but not least, we should state that even if the current research's leading target group was employees with bipolar disorder, the insights we obtain from the findings are generalizable to other neurotic disorders and psychosis. The research question that we focused and the methodology that we have followed may inspire future research to explore the experiences of other disadvantageous groups in Turkey.

4.4. Conclusion

The current study focused on the work-life experiences of individuals with bipolar disorder, a topic has not previously been researched in Turkey. A similar study (Michalak, Yatham, Maxwell, Hale, & Lam, 2007) which was conducted in Canada, gave some typical results. For example, they identified the theme of "productivity" in mania, communication difficulties and being withdrawn from people in depressive episodes.

Most of the participants in the current study had a desire to work. However, the idea of exposure to stigma creates a barrier to start work or maintain the work. Not only public stigma, but also self-stigma makes a start to a job challenging. When the studies examining the effects of stigma on people with psychological disorders are investigated that public stigma has powerful effect on creating self-stigma (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012). Public stigma does not only negatively affect one's self in the social relationship, but also builds permanent destructive effect (self-stigma) on the person. Instead of benefiting from the therapeutic effects of the job, people can move away from social environments.

The most significant effect of working on bipolar disorder is helping people to create a routine. Marie Jahoda's theory of latent functions of work has

also supported this advice (Furnham, 1992). Furthermore, P5 who stated "development of social skills" supports Jahoda's latent functions of work because work settings are an excellent opportunity to develop social skills.

The findings of this study will cause to build new intervention methods with the intersection of clinical psychology and organizational psychology disciplines because there is a need to nourish occupational functionalities. Moreover, awareness of organizations about psychological disorders and psychological well-being/health should be raised.

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Appendix 1

MÜLAKAT SORULARI

1. Öncelikle kendinizi tanıtabilir misiniz? (Yaş, iş tecrübesi, eğitim ve diğer demografik bilgiler)
2. Şuanda aktif olarak çalışıyor musunuz? Mesleğiniz nedir? Ne kadar zamandır çalışıyorsunuz? Bir önceki iş tecrübenizden ve şuanki iş tecrübenizden bahsedebilir misiniz? (İş değiştirdiniz mi? İş değiştirmenizi etkileyen faktörler nelerdir?
3. Bipolar bozukluk tanınız iş deneyiminize nasıl yansıyor?
4. İş arkadaşlarınız ya da yöneticiniz bipolar tanısı aldığınızı biliyor mu? Size karşı ve bu tanıya karşı tutumlarını nasıl değerlendiriyorsunuz?
5. Sizce Türkiye'de yaşayan insanlar bipolar bozuklukla ilgili yeterince bilgiye sahipler mi? Daha da özelleştirirsek insan kaynakları profesyonelleri bu konuda bilgili mi?
6. Hiç işsiz kaldığınız bir dönem oldu mu? Ne kadar uzunlukta sürdü ve neden ayrıldınız? Bu tecrübeyi nasıl anlatırsınız? Bipolar bozuklukla herhangi bir bağlantısı var mı?
7. İş görüşmelerinde bipolar tanısı aldığınızı paylaşmayla ilgili ne düşünüyorsunuz?
8. Çalışma konusunda ne düşünüyorsunuz? Sizce terapötik bir etkisi var mı?

Appendix 2

SEMI-STRUCTURED INTERVIEW QUESTIONS FOR BIPOLAR SAMPLE

1. Could you introduce yourself? (Age, job experience, education and other demographic data)
2. Are you actively working? What is your job? How long have you been working? Could you tell me about your previous job experience and current one? (Did you change your job? Which causes were affected to change your job?)
3. How do you experience the effect of your bipolar disorder on your work life?
4. Do your manager/co-workers or other people know that you are an individual with bipolar disorder? How are their attitudes toward you/your disorder?
5. Do you think that people (overall in public life) in Turkey are well informed about bipolarity? What about HR people specifically?
6. Have you ever experienced a period of unemployment? How long and why? How would you describe this experience? Was that related to your disorder?
7. What do you think about mentioning/ disclosing your disorder during the job interviews?
8. What do you think about working? Does it have a therapeutic effect?

Appendix 3

GÖNÜLLÜ KATILIM FORMU

Bu tez çalışması, bipolar tanısı almış kişilerin iş yeri ve iş deneyimleri ile insan kaynakları alanında çalışan kişilerin bu tanıyı alan kişilere karşı tutumları hakkında bilgi edinmeyi amaçlamaktadır.

Tez çalışması Istanbul Bilgi Üniversitesi, Örgütsel Psikoloji bölümü öğrencisi Faruk Ceylan ve danışmanı Doç. Dr. İdil Işık tarafından yürütülmektedir.

Bu araştırmada yarı yapılandırılmış sorulardan oluşan derinlemesine görüşme yapılacaktır. Ortalama görüşme süresi 1 saat olarak belirlenmiş olup, az ya da daha fazla da sürebilir. Katılımcıların kişisel ve çalıştıkları firma bilgisi gizli tutulacak ve elde edilen bilgiler sadece bilimsel amaçla kullanılacaktır.

Katılımınız tamamen gönüllülük üzerine kuruludur. Çalışma sırasında sebep bildirmeksizin çalışmayı bırakabilirsiniz. Araştırmaya katıldıktan sonra herhangi bir sorunuz olduğu takdirde ya da araştırma sonuçlarını elde etmek için Faruk Ceylan ya da İdil Işık ile irtibata geçebilirsiniz.

Yukarıdaki çalışmanın amacını ve içeriğini belirten bildiriyi okudum, anladım ve araştırmaya katılmayı kabul ediyorum. Lütfen aşağıdaki boşluğa kendi el yazınızla **"Bu araştırmaya kendi isteğimle katılıyorum"** yazınız. _____ Adı Soyadı: İmzası	**İletişim Bilgileri:** Faruk Ceylan farukceylan118@gmail.com

Appendix 4

Informed Consent Form

The objective of this thesis study is to examine the workplace experiences of workers with bipolar disorder and human resources management professionals' attitudes.
The study is going to be held by Organizational Psychology master student Faruk Ceylan and his advisor İdil Işık in İstanbul Bilgi University.
In-depth interviews with semi-structured questions will be done in this research. The interviews will last for approximately one hour. Personal information of the participants will be kept in private and the finding of the study will only be used for scientific purposes.
It is voluntary to participate in this study. You can quit any time during the interview and/or skip any question that you do not want to answer without mentioning an excuse.
If you accept, there will be audio-recording during the interview. We prefer audio-recording in order not to miss any information during our interview. Voice records will be transcribed and interpretative phenomenological analysis will be conducted. Not to mention from your name and your organization name will be taken care of. The data collected from participants will not be used individually, they will be combined in a data pool and analysis will be conducted as a whole.
You can contact to İdil Işık (idil.isik@bilgi.edu.tr) and Faruk Ceylan (farukceylan118@gmail.com) if you have any further question on the study.
I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
I accept ( ) I do not accept ( )
I accept audio recording ( ) I do not accept ( )
Please write “I accept to participate”:

Signature and contact information of the researcher
Date
If there is, Name-Surname of Participant’s
Surrogate:.....
Signature :.....

Appendix 5

ETİK KURUL DEĞERLENDİRME SONUCU/RESULT OF EVALUATION BY THE ETHICS COMMITTEE

(Bu bölüm İstanbul Bilgi Üniversitesi İnsan Araştırmaları Etik Kurul tarafından doldurulacaktır /This section to be completed by the Committee on Ethics in research on Humans)

Başvuru Sahibi / Applicant: Faruk Ceylan

Proje Başlığı / Project Title: Workplace Experiences of Employees with Bipolar Disorder and Human Resources Management Professionals' Attitudes

Proje No. / Project Number: 2018-20024-94

1.	Herhangi bir değişikliğe gerek yoktur / There is no need for revision	XX
2.	Ret/ Application Rejected Reddin gerekçesi / Reason for Rejection	

Değerlendirme Tarihi / Date of Evaluation: 10 Temmuz 2018

Kurul Başkanı / Committee Chair
Doç. Dr. Itır Erhart

Üye / Committee Member
Prof. Dr. Aslı Tunç

Üye / Committee Member
Prof. Dr. Hale Bolak

Üye / Committee Member
Prof. Dr. Turgut Tarhanlı

Üye / Committee Member
Prof. Dr. Koray Akay

Üye / Committee Member
Prof. Dr. Ali Demirci

Üye / Committee Member
Prof. Dr. Ayhan Özgür Toy